

# ***Erin Mills Optimum Health***

3105 Glen Erin Drive, Suite 5

Mississauga, Ontario

L5L 1J3

Phone: (905) 828-2014 | Fax: (905) 828-8822

## **Motor Vehicle Accident** **Patient Information**

*In order for us to best serve you, and process your Claim promptly please provide all information as soon as possible.*

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## **Car Insurance Information:**

**Insurance Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

## **Work Information:**

**Place of employment:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## **Your work insurance information (extended health):**

**Company Name:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Employee Policy Number: \_\_\_\_\_

Employee Claim Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Please turn over →**

**Your spouse's work insurance:**

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Postal Code: \_\_\_\_\_

Employee Policy Number: \_\_\_\_\_

Employee Claim Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Please give a brief description of the accident and what happened to you. Please describe any injuries as a direct result of the accident:**

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**We will gladly assist you in understanding your insurance coverage, but you agree that you are responsible for your account.**

**I have read the above and consent to care at the Erin Mill's Chiropractic Centre.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient's Signature

*\* Please provide our office with any information forms concerning your accident that need to be filled out.*