Erin Mills
Optimum Health
3105 Glen Erin Drive, Suite 5
Mississauga, Ontario L5L 1J3
(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:

_____
_____
_____
_____
_____
_____
_____

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.***