Patient Lien Form

NOTICE: THIS INFORMATION MUST BE RETURNED NO LATER THAN YOUR SECOND VISIT. WE CAN NOT TREAT YOU UNTIL INFORMATION HAS BEEN RECEIVED.

Patient Name: (please print)______________________________________

Address:____

City:_____________________ **State:**______ **Zip:**__________________

Date of Loss:_______________

Place where Accident Happened:____

City:____________ **County:**___________________ **TIME OF DAY:**_____________________

MED PAY INFORMATION

INSURANCE COMPANY NAME:____

ADDRESS:__________________________ **CITY:**_____________________

STATE:_______________ **ZIP CODE:**_______ **PHONE#:**____________________________

CLAIM#____________________ **POLICY#**_____________ **ADJUSTER:**_________________

THIRD PARTY INFORMATION

INSURANCE COMPANY NAME:______________________________________

ADDRESS:__________________________ **CITY:**_____________________

STATE:_______________ **ZIP CODE:**_______ **PHONE#:**____________________________

CLAIM#____________________ **POLICY#**_____________ **ADJUSTER:**_________________

INSURED'S NAME:__________________________

ATTORNEY INFORMATION

ATTORNEY NAME:____________________ **NAME OF FIRM:**_______________________

ADDRESS:___________ **CITY:**_____________ **STATE:**_____________ **ZIPCODE:**_________

PHONE:_________________________