

**SAND POINT INTERISTS
MOTOR VEHICLE ACCIDENT FORM**

Name _____

Date of Accident _____

Time _____

Place _____

How did the accident occur?

List symptoms felt after impact _____

List symptoms felt the next day _____

List symptoms felt today _____

For billing purposes please check whom we are billing:

____ Health Insurance ____ PIP (Personal Injury Protection under auto ins)

(Please note: We do not bill 3rd party/other insured for auto injury claims)

If you marked PIP, please provide the following:

Name of Auto
Insurance _____

Policy # _____ Claim # _____

Name/telephone # of claims adjuster _____

Claims address _____

Were you treated at a hospital and if so which one? _____

I agree to be financially responsible for these services

Signature: _____