BEAR MRI
AND IMAGING CENTER

MVA/WORKERS COMP/PERSONAL INJURY INFORMATION

PATIENT NAME: _____ **DOB:** _____

TYPE OF ACCIDENT (circle one): Motor Vehicle Workers Comp Personal Injury

DATE OF ACCIDENT: _____

STATE ACCIDENT OCCURRED: _____

INSURANCE CO NAME: _____

CLAIM NUMBER: _____

CLAIM ADDRESS:

_____

_____

_____

ADJUSTOR NAME: _____

ADJUSTOR PHONE NUMBER: _____

ADJUSTOR FAX NUMBER: _____

ATTORNEY NAME: _____

ATTORNEY PHONE NUMBER: _____

***** ***I CERTIFY THE ABOVE INFORMATION PROVIDED BY ME IS TRUE AND ACCURATE***

PATIENT SIGNATURE:_____ **DATE:** _____

(OFFICE USE ONLY)

CLAIM OPEN & ACTIVE PER _____

CLAIM CLOSED PER _____

COMMENTS_____