## AUTO ACCIDENT INFORMATION

**Patient Name**:
**Attending Physician**:
**Date of Birth**:
**Medical Records Number:**
**Claim Number:**

**Good Samaritan Medical Group Specialists**
3219 Central Ave, Ste. 200
Kearney, NE 68847
Phone (308)865-2370
Fax (308)865-2843

**Good Samaritan Medical Group Orthopaedic Surgery/Sports Med**
3219 Central Ave, Ste 102
Kearney, NE 68847
Phone: (308) 865-2600
Fax: (308) 865-2838

### AUTO INSURANCE INFORMATION

Name of person clam is being filed under: _____
Address of Insured: _____
_____
_____
Telephone: _____Injury Verified By (for office use)_____
Contact Person: _____

### INSURANCE CARRIER FOR CLAIM

Auto Insurance Carrier _____
Carrier Address _____
_____
Carrier Phone Number _____ Coverage Verified by _____
Adjuster's Name _____ Claim # _____

### INJURY INFORMATION

Date of Injury _____ Time _____ am pm
Place of Injury _____
Accident reported to police? Yes No Name of officer you reported to: _____
Give full description of how accident happened _____
_____
_____
_____
_____
_____

Was the accident faulted to anyone? Yes No Who? _____
Other doctors seen from this condition: Yes No
Doctor's Name _____
Were X-rays taken? Yes No Other test? Yes No
If yes, by whom? Please list test(s) and result(s)
_____
_____
_____

Any previous auto accident injuries? Yes No
Date(s) of previous injuries _____
Describe previous auto accident injuries _____
_____

### AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Auto Accident Insurance benefits is denied.

Patient's Signature: _____ Date: _____