PARKWAY MEDICAL ASSOCIATION

1600 S. Crain Highway Ste. 201
Glen Burnie MD 21061
(P) 410-760-0098; (F) 410-761-9131

Accident/Injury Information Sheet

Patient Name: _____ DOB:_____

Acc.#:_____ Date of Accident/Onset:_____

Related to (circle) Automobile Home Work Other

How did the Accident/Injury/Onset occur:

_____
_____
_____
_____
_____
_____
_____

Insurance Company Name:_____
Address:_____
City:_____State:_____Zip Code:_____
Claim Adjuster Name:_____
Contact Number:_____Fax Number:_____
Claim Number:_____

- I acknowledge that if the above insurance company fails to pay charges related to my accident I will be responsible for any co-payments and deductibles or unpaid financial statements on all dates of services related to the accident.

Patient Signature:_____Date:_____

Verified Claim With:_____Date:_____

Verified by:_____