Lincoln Orthopaedic Center

Dedicated Surgical Expertise

Auto or Accident Information

Patient Name:_____ Account#:_____
Type and date of injury:_____

_____

Location/address of accident:_____
Have you reported this to an insurance company? No___ Yes___to whom?_____
Patient's Health Insurance:_____

Complete this section only for property (non-motor vehicle) accidents:
Insurance Carrier for the Property Where Accident Occured:_____
Claim Filing Address:_____
Claim Adjuster Name & Phone #_____
Claim #_____
What were you doing at the time?_____

_____

Complete this section only for motor vehicle accidents:
Patient's Auto Insurance Carrier:_____
Claim Filing Address:_____
Claim Adjuster Name & Phone #_____
Claim #_____
Other Vehicle Auto Insurance Carrier:_____
Claim Filing Address:_____
Claim Adjuster Name & Phone #_____
Claim #_____Driver/Insured's Name:_____

Was an accident report filed? No____ Yes____where?_____

(Please attach a copy of the report if the accident occurred outside Lincoln, NE.)

Were you (circle one): driver passenger pedestrian other_____

Have you retained an attorney regarding this accident? No___ Yes___name, phone, & address:_____

_____

I agree that if the above insurance denies any services I receive from Lincoln Orthopaedic Center, P.C. that I am personally and fully responsible for payment for any charges incurred.
I hereby authorize the release of any medical information necessary to process my liability insurance and request payment of benefits to the provider of services.

Signature_____ Date_____