Automobile Accident

Name ______________________ Date ______________

Date of Accident ______________

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE VEHICLE YOU WERE DRIVING OR RIDING IN:

Owners Name: ______________ State car registered: _______

Address ____

Phone Number: ______________

Vehicle's Auto Insurance Company

Name ____

Address ____

City ______________ State _______ Zip ______________

Phone Number ______________________

Adjuster's Name ____________________________

Have you reported your injury to the auto insurance company? | YES | NO |

What part of the body?____________________________________

Claim Number: ____________________________

Please complete the following Authorization and Assignement form for claims under Maryland's, "No-Fault" (Personal Injury Protection) or PIP Coverage.

I, ______________________ Authorize the physicians of The Orthopaedic Center, P.A. to furnish the insurance company listed above, any information it may request in reference to the injuries sustained by me, my spouse or children(s) on ________. I also request that the insurance company pay directly to The Orthopaedic Center P.A., any "PIP" benefits due me on their bill for professional services rendered in connection with these injuries.

Signature ____________________________ **Date** ______________