WILD QUARTZ WELLNESS
massage therapy & holistic healing

Motor Vehicle Accident Form

Name: _____ Date of Accident: _____

Who was at fault? (You or Other party) _____

Was the vehicle you were in insured at the time of accident? _____

Was a police report issued? If yes, Police Report number_____

Have you gone to a hospital or seen any other doctor? ( ) Yes ( ) No

If yes than where? _____

Images, i.e. MRI, Xray, Ultrasound: _____

Are your work activities restricted because of this injury? ( ) Yes ( ) No

Personal Auto Insurance or Vehicle you were in:

Name of the policy holder: _____

Relationship to the policy holder: _____

Address of insurance company: _____

Insurance company phone #: _____

Other Party's Auto Insurance Info:

Name of the policy holder: _____

Address of insurance company: _____

Insurance company phone #: _____

Adjuster's name: _____ Adjuster's number: _____

Policy #: _____ Claim #: _____

Did you retain a Lawyer? _____ Name of attorney: _____

Phone Number of Attorney: _____

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PH: 760.523.8500 E: nikky@wildquartzwellness.com

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In your own words, describe the accident:

_____

_____

_____

_____

Describe your symptoms:

_____

_____

_____

_____

I hereby authorize Wild Quartz Wellness to obtain or release any information to the insurance company, attorney, or referring physician upon request. I assign payment of medical benefits to Wild Quartz Wellness and understand that I am financially responsible for any charges not covered by my insurance carrier.

Patient's Signature: _____ Date: _____

Print Name: _____

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