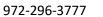
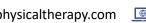


972-296-1808





advance physical the rapy.com



Personal Injury Information Form Datient Name

ratient ivaine.					DOB.				
Date of Accident:					Time of Accid	dent:			
Your Law Firm:									
Name of Attorney/ Case Manager:									
1. Motor Vehicle Acci	dents:								
Your Personal Car Insurance:					Claim Number:				
Adjustor's Name:									
Email:					Phone:				
Make and Model of your Vehicle:					Year:				
Your Position in the vehicle:		river	☐ Passenge☐ Driver Sig						
Speed of your vehicle:			topped Parked Noving at Appx MPH		_		g Accelerating		
Collision Type:	ollision Type: ☐ Front II☐ Rear In						☐ Passenger Side		
Road/ Street Name:	rreet Name:				City/ State:				
Other Vehicle involved	d Make	and M	odel:						
Their Car Insurance:					Was Police Report Filed: ☐ Yes			□ No	
Other relevant details	about a	accider	nt:						
2. Non-Motor Vehicle	Accide	nts:							
Please describe your a	accident	and h	ow you got injur	ed:					

DOD:

I understand that I and my attorney must agree to the terms of Advance Therapy PC "Letter of Protection/ Lien" to pay my bills.

Patient Signature: ___