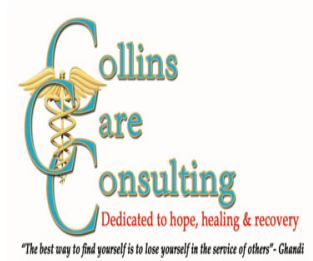


24123 Greenfield Rd
Suite 306
Southfield, MI. 48075
Tel: 248-701-0854
Email: collinscareconsulting@gmail



CLIENT INTAKE FORM-AUTO

Client Name _____ Phone: _____

Address: _____

SS# _____ DOB: _____

Identification No _____

Emergency Contact/Secondary Number: _____

Marital Status: Married. Single. Divorced. Separated. Never Married

If separated, spouses name and address _____

Email: _____

Occupation: _____ Employers Name: _____

Injuries Sustained: _____

PREVIOUS HEALTH INFO/HEALTH INSURANCE

Pre-existing Health Information: _____

Allergies: _____

Primary PCP: _____ Contact # _____

Primary Health Insurance: _____

Policy Holder: _____ Group# _____

ACCIDENT INFORMATION

Date of Accident: _____ Those Involved: _____

Police Report Filed: Yes No Police Report# _____

Hospital: _____ Arrive via Ambulance? Yes No

Test taken at Hosp? _____ Type of Test Taken _____

Hospital Referrals? _____

PIP AUTO INSURANCE INFORMATION

Insurance at time of accident: _____ Type of Insurance _____

Policy Holder: _____ Relation: _____

Policy Number: _____ Claim# _____

PIP Policy Limits _____ PIP Opt Out. Yes. No

Adjuster: _____

P: _____ F: _____

Address: _____

BI AUTO INSURANCE INFORMATION

Insurance at time of accident: _____ Type of Insurance _____

Policy Holder: _____

Policy Number: _____ Claim# _____

PIP Policy Limits _____ BI Excess Yes. No

Adjuster: _____

P: _____ F: _____

Address: _____

TREATING PROVIDERS

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Dates of Service: _____ Provider Type: _____

Test Taken: _____

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Dates of Service: _____ Provider Type: _____

Test Taken: _____

Provider/Facility Name: _____

Address: _____

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ACCIDENT DETAILS

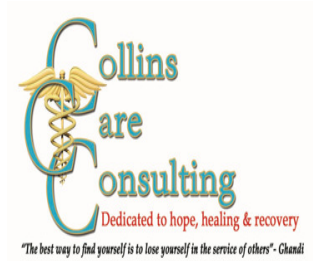
MISC NOTES

Referred By: _____

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Test Taken: _____

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Test Taken: _____

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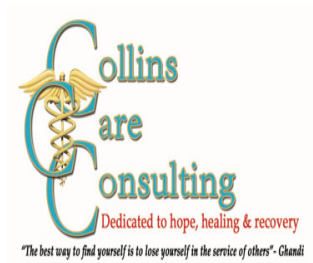
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Dates of Service: _____ Provider Type: _____

Test Taken: _____

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Address: _____

Phone: _____ Fax: _____

Dates of Service: _____ Provider Type: _____

Test Taken: _____

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Dates of Service: _____ Provider Type: _____

Test Taken: _____

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Dates of Service: _____ Provider Type: _____

Test Taken: _____

ACCIDENT DETAILS

MISC NOTES

Referred By: _____

Date: _____

