The firm of Meyer Christian & Associates

# Patient Incident Questionnaire

## Patient Information

**Patient Name**_____ **File Number** (from the cover letter)_____

Phone_____ Email_____ Birth Date_____

## Accident Information ----------

*Please circle YES or NO*

Were you in an accident? YES NO Date of Injury_____

*If NO, circle NO and please return in the enclosed envelope. If YES, please continue.*

Was this an auto accident? YES NO If NO, what type_____

Were you at fault? YES NO If NO, who is _____

Have you hired an attorney? YES NO Did you file a claim? YES NO

*If you answered* YES *to either of the above, please continue. If* NO*, please return.*

## Attorney Information ----------

Attorney's Name_____ Phone_____

Address _____

## Insurance Information ----------

Other Party's Insurance Company_____

Policyholder's Name _____

Policy Number_____ Claim Number _____

Address_____ Phone_____

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Your Insurance Company _____

Policyholder's Name _____

Policy Number_____ Claim Number _____

Address_____ Phone_____

## SIGNATURE REQUIRED ON REVERSE SIDE

**For questions or more information call (888) 278-7393**

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