Premier Health Partners, PC
No-Fault

SUPPLEMENTAL INFORMATION FORM

TODAY'S DATE:	**Date of Birth:**
Patient's Name:	**Social Security No:**
Date of Accident:	**Are You Currently Out of Work as a Result of this Accident:** □ **Yes** □ **No**
Briefly Describe WHAT Injury you Sustained:	

NO-FAULT INSURANCE CARRIER INFORMATION

Insurance Carrier Name:	Insurance Carrier Address:
Claim Number:	Name of Adjuster:
Phone: ( )	Fax: ( )

ACCIDENT DETAILS

Location of Accident:
Briefly Describe **HOW** Injury Occurred:
Were you a: □ Driver □ Passenger □ Pedestrian
If Driver or Passenger, were you: □ Belted □ Not-Belted
Have you Filed a Claim with your Carrier: □ Yes □ No
Have you Completed and Returned your No-Fault Application: □ Yes □ No

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:
Phone: ( )	Fax: ( )
Signature:	**Date:**