RAND O. TORMAN, D.C., P.C.

Addendum to AUTOMOBILE ACCIDENT QUESTIONNAIRE

In order to bill the automobile insurance to cover your treatments, we need the following information in reference to the vehicle that you were in:

Patient Name: ______________________ Date of Accident: ________________

The state in which the accident occurred: _________

A. Insurance Information on the vehicle you were in:

1. Person to whom car is registered/insured:

   Name: ______________________ Relationship to patient: ___________

   Address: ____

   ____

2a. Auto Insurance Agent:

   Name: _____________________________ Phone: ___________________

   Address: ____

   ____

OR

2b. Auto Insurance Carrier/Company:

   Name: __________________________ Claim #: _____________________

   Address: ____

   ____

   Phone: _________________ ext #: _______ Contact: ________________

B. HEALTH INSURANCE (Note: we must be participating with your health Insurance to assure payment by Auto Insurance)

Policy ID#: ________________________

Subscriber's Name: __________________________ Relationship to patient: ________

Subscriber's Address: ____

(if different than Patient's)

Insurance Co. Name: ______________________________ Phone:_______________

Insurance Co. Address____

C. ATTORNEY:

Name:_________________________________ Phone: ____________________

Address: ____