Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

Last	First	MI
ID#		

(Place patient label here)

Patient Name _____

University ID #_____ Date of Birth _____

Preferred Phone Number_____ Date of Accident _____

Insurance Company Name _____

Telephone Number _____ Fax Number_____

Address _____

Policy #_____ Claim # _____

Adjuster's Name_____

Please check one response below to describe your accident:

□ I was the driver of a car
□ I was the passenger of a car
□ I was the driver of a motorcycle
□ I was the passenger of a motorcycle
□ I was the bicyclist
□ I was the bicyclist struck by a car
□ I was a pedestrian
□ Other _____

Please describe your injuries: _____

_____

_____

Attorney Name_____

Address_____

Telephone Number _____ Fax Number_____

I have signed a release for information to be sent to my insurance company and/or my attorney.

Patient Signature _____ Date_____

MOTOR VEHICLE ACCIDENT INFORMATION
(For Billing Purposes Only)