

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)