

# MOTOR VEHICLE ACCIDENT FORM

**Office Use Only:** \_\_\_\_\_ (CSR initial)  
\*My initial signifies that the information on this form has been uploaded into the EMR.

*\*If you are currently being treated for this accident at another facility, please notify someone from our reception area before moving on.*

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

*Provide your email and receive specials, health topics, & more!*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex at Birth:  M  F  Other Marital Status:  Married  Single

Mailing Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

Address 2: \_\_\_\_\_

**What is your preferred method of communication?**  Cell Phone  Home Phone  Email  Mail

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_ Hispanic/Latino:  YES  NO

**How did you hear about us?**  Drive By  Insurance  Doctor (Referring Physician/Hospital: \_\_\_\_\_)  
 Employer  Friend/Family  Hotel  Internet  Instagram  Facebook  
 First Aid Station/Event (Please specify): \_\_\_\_\_

**Preferred Pharmacy City:** \_\_\_\_\_ **Preferred Pharmacy Zip Code:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

I do not have a primary care physician  I don't know who my primary care physician is

**EMERGENCY CONTACT/NEXT OF KIN \*Please provide the BEST contact numbers for each contact**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**MVA ACCIDENT DETAILS**

**Please note:** Hawaii is considered a "no-fault state", which means **your motor vehicle insurance company will pay the bills for your injuries and your passengers' injuries** up to the personal injury protection benefits ("PIP") limit. (<http://cca.hawaii.gov/ins/consumer/mvi/>)

**Accident Date:** \_\_\_\_\_ **Were you the:** \_\_\_\_ Passenger \_\_\_\_ Driver

**Have you been to any doctor(s) office or hospital before today for this accident?** \_\_\_\_ Yes \_\_\_\_ No

**Please describe what happened:**

\_\_\_\_\_

**MOTOR VEHICLE INSURANCE COVERAGE \*This is the MVA insurance of the owner of the vehicle you were in**

Insurance Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Insured Mailing Address: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Best Contact Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number (If Applicable): \_\_\_\_\_

**GUARANTOR'S INFORMATION \*Please include your information if you are checking in a patient younger than 18 years old.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address City/State/Zip Code*

**Print Name of Patient or Guardian:** \_\_\_\_\_

**Signature of Patient or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_