MOTOR VEHICLE ACCIDENT FORM

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

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

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 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 a 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'SINFORMATION **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*

I certify that the information provided is correct to the best of my knowledge. I will not hold Urgent Care Hawaii, LLC, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. I understand that I may contacted by URGENT CARE HAWAII's billing dept, acting on behalf of Urgent Care Hawaii, LLC regarding any financial responsibilities.

Print Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ **Date:**_____