PORTLAND
URGENT CARE
portlandurgentcare.com
contact@portlandurgentcare.com
fax: 503-719-6829

PORTLAND
WELLNESS CARE
portlandwellnesscare.com
contact@portlandwellnesscare.com
fax: 503-477-9958

4160 NE Sandy Blvd., Portland, Oregon 97212 | 503-249-9000

ACCIDENT REPORT

DATE:

PATIENT NAME _____ MOBILE PHONE: _____

VEHICLE ACCIDENT: ☐ YES ☐ NO

DATE OF ACCIDENT _____ TIME _____ AM _____ PM

WERE YOU: ☐ DRIVER? ☐ PASSENGER? ☐ PEDESTRIAN? ☐ ON BICYCLE? ☐ ON MOTORCYCLE?

WERE YOU STRUCK FROM ☐ BEHIND? ☐ RIGHT? ☐ LEFT? ☐ HEAD-ON?

WERE YOU WEARING A SEAT BELT? ☐ YES ☐ NO

WERE YOU DRIVING WHILE WORKING? ☐ YES ☐ NO

TYPE OF INJURY: _____ CITY | STATE _____

DID THE INJURY OCCUR AT WORK? ☐ YES ☐ NO

DID YOU REPORT THE INJURY TO MGMT? ☐ YES ☐ NO

BRIEFLY DESCRIBE HOW THE INJURY OCCURRED: _____

_____

PRIVATE MEDICAL INSURANCE: _____

HAVE YOU RECEIVED A SETTLEMENT? ☐ YES ☐ NO

HAVE YOU RETAINED AN ATTORNEY? ☐ YES ☐ NO

NAME OF ATTORNEY: _____ PHONE: _____

IF VEHICLE ACCIDENT:

DID YOU FILE A CLAIM WITH YOUR VEHICLE INSURANCE POLICY: ☐ YES ☐ NO

NAME OF POLICY HOLDER _____ DATE OF BIRTH: _____

ADDRESS OF POLICY HOLDER _____

PHONE # OF POLICY HOLDER _____
(IF DIFFERENT THAN PATIENT)

VEHICLE INSURANCE COMPANY: _____ PHONE: _____

CLAIM NUMBER: _____ POLICY NUMBER: _____

NAME OF OTHER DRIVER: _____

OTHER DRIVER'S INSURANCE COMPANY: _____

☐ I HEARBY CERTIFY THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE