ALAN J. ZEND, D.O.
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EDMONDS, WA 98026
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ACCIDENT INSURANCE QUESTIONNAIRE FORM

PATIENT NAME_____

(If patient is not the primary insurance holder, please state name and date of birth of that person for

PIP insurance billing purposes_____

PATIENT ADDRESS AND PHONE #_____

_____

PATIENT PERSONAL INJURY PROTECTION (PIP) INSURANCE INFORMATION

NAME OF INSURANCE CO._____

ADDRESS AND PHONE # OF PIP CLAIMS OFFICE_____

PIP CLAIM #_____DATE OF ACCIENT_____

EXPLAIN ANY EXTENUATING CIRCUMSTANCES, IE, PEDESTRIAN, PASSINGER IN CAR, DRIVING SOMEONE

ELSE'S CAR ETC, _____

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR. I UNDERSTAND AND ACCEPT THAT I AM FINANCIALLY RESPONSIBILITY FOR ANY BALANCE DUE.

Signature of patient (parent, if patient is under age 18) Date