

Rehabilitation Options of Issaquah Auto Questionnaire

Date: _____ / _____ / _____
Patient Name: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Patient Phone: _____ Other Phone: _____
Patient SSN: _____ Sex: _____ Date of Birth: _____
Spouse's Name: _____ Date of Birth: _____
Spouse's SSN: _____
Date of Auto Accident: _____
Place of Auto Accident: _____
City: _____ State: _____ Zip: _____
Please explain in detail how your accident happened: _____

Your Insurance Co Name: _____
Insurance Co Address: _____
City: _____ State: _____ Zip: _____
Insurance Co Phone: _____ Ext: _____
Policy#: _____ Claim#: _____
Name of Your Insurance Adjustor: _____

Your Attorney's Name (If applicable): _____
Attorney's Phone: _____ Ext: _____

Sign below to give permission for ROI to contact attorney above:

X _____

Driver of other vehicle Info (If any)

Person's Name: _____ Phone: _____

Person's Address: _____

City: _____ State: _____ Zip: _____

Their Insurance Co Name: _____

Their Insurance Co Address: _____

City: _____ State: _____ Zip: _____

Their Insurance Co Phone: _____ Ext: _____

Policy #: _____ Claim #: _____

Name of Their Insurance Adjustor: _____

Often times PIP coverage will exhaust during treatment. If we are contracted with your regular health insurance we will bill them for your services. If you do not have regular health insurance we offer a cash discount. We require payment at each appointment.