Family Center for Health Care
At Citizens Health

310 East College Drive
Colby, KS 67701

Tel: (785) 462-6184 / Fax: (785) 460-1490
www.cmciks.com

- **PATIENT INFORMATION**

Patient Name: ______________________ SS#: ______________________

Home Phone: ______________________ DOB: ____ Age: ____

Patient's Address: ______________________

- **MOTOR VEHICLE ACCIDENT (MVA)**

Auto Ins Co Name: ______________________ Phone No: ______________

Ins Co Address: ______________________ Agent Name: ______________

Policy No: ______________________ Claim Number: ______________

Named of Insured, If other than patient: ______________ Phone Number: ______________

Address of Insured, If other than patient: ______________________

This should always be your own personal auto information, even if the accident was not your fault or you were not in your own auto, or if you were only a passenger. – If you do not have insurance coverage of your own, and you were a passenger, give the driver's auto insurance.

- **WORK COMP (*Please fill out back side of this form if Work Comp Related*)**

Employer's Name: ______________________

Address: ______________________
Street City State Zip

Phone Number: ( ) ______________ Contact, for approval: ______________

- **INDUSTRIAL or LIABILITY (PERSONAL PROPERTY INJURY; COMPANY PHYSICAL, OTHER)**

(Circle One)

Responsible Party: ______________________ Relationship to patient: ______________

Address: ______________________
Street City State Zip

Phone Number: ( ) ______________ Contact, for approval: ______________

- **GIVE A DETAILED DESCRIPTION OF THE INJURY:**

WHERE (be specific as to room, outside): ____________________

DESCRIBE THE ACTIVITY AND HOW IT OCCURED: ____________________

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Date of Injury: ____________________ Date Last Worked Prior to Injury: ____________________

I understand that I am financially responsible for any and all charges not covered by the above named insurance company.

Signature: **Date:**