Neurology Consultants of Kansas
2135 N. Collective Lane
Wichita, KS 67206-3560

INJURY / MVA INFORMATION FORM

Patient Information

Legal Name: _____ SSN: _____ /_____ /_____
(LAST) (FIRST) (MIDDLE)

Home Phone: _____ - _____ - _____ DOB: _____ /_____ /_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Motor Vehicle Accident (MVA) Information

**Auto Insurance Company Name: _____ Phone number (_____) _____ - _____

Insurance Company Address: _____ Agent name: _____

City: _____ State: _____ Zip Code: _____ Date of injury: _____ / _____ / _____

Policy Number: _____ Claim number: _____

Name of Insured if other than patient: _____ Phone number (_____) _____ - _____

Address of Insured if other than patient: _____

**** This information 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.**

Worker's Compensation Information

Employer's Name: _____ Phone number (_____) _____ - _____

Employer's Address: _____ City: _____ State: _____ Zip Code: _____

Date of injury: _____ / _____ / _____ Claim number: _____

Person to contact for approval: _____ Phone number (_____) _____ - _____

Address of Insured if other than patient: _____

Industrial or Liability (Personal Property Injury, Company Physical, Other) **Circle One**

Responsible Party: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Person to contact for approval: _____ Phone number (_____) _____ - _____

Date of injury: _____ / _____ / _____ Claim number: _____

(over)