Adventist Health Castle

MOTOR VEHICLE ACCIDENT FORM

If you are currently being treated for this accident at another facility, please notify someone from our reception area before moving on.

Office Use Only:_____ (CSR initial)
**My initial signifies that the information on this form has been uploaded into the EMR.*

PATIENT INFORMATION

First Name:_____ Last Name:_____ Suffix:_____

SSN:_____-_____-_____ Home Phone:_____ Cell Phone:_____

Middle Name:_____ Email Address:_____

Provide your email and receive specials, health topics, & more!

Date of Birth_____/_____/_____ Sex at Birth: ❑M ❑F ❑Other Marital Status: ❑Married ❑Single

Mailing Address:_____ City/State/Zip Code:_____

Address 2:_____

What is your preferred method of communication? ❑ Cell Phone ❑ Home Phone ❑ Email ❑ Mail

Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ YES ❑ NO

How did you hear hear about us? ❑ Drive By ❑ Insurance ❑ Doctor (Referring Physician/Hospital:_____)
❑ Employer ❑ Friend/Family ❑ Hotel ❑ Internet ❑ Instagram ❑ Facebook
❑ First Aid Station/Event (Please specify):_____)

Preferred Pharmacy City:_____ **Preferred Pharmacy Zip Code:**_____

Primary Care Physician:_____ **Phone Number:**_____

❑ *I do not have a primary care physician* ❑ *I don't know who my primary care physician is*

EMERGENCY CONTACT/NEXT OF KIN **Please provide the BEST contact numbers for each contact*

1. Name:_____ Relationship:_____ Phone Number:_____
2. Name:_____ Relationship:_____ Phone Number:_____

MVA ACCIDENT DETAILS

Please note: *Hawaii is a considered a "no-fault state", which means* ***your motor vehicle insurance company will pay the bills for your injuries and your passengers' injuries*** *up to the personal injury protection benefits ("PIP") limit. (http://cca.hawaii.gov/ins/consumer/mvi/)*

Accident Date:_____ **Were you the:** ____ Passenger ____ Driver

Have you been to any doctor(s) office or hospital before today for this accident? ___ Yes ___No

Please describe what happened:

_____

_____

MOTOR VEHICLE INSURANCE COVERAGE **This is the MVA insurance of the owner of the vehicle you were in*

Insurance Name:_____

Insured Name:_____ Relationship:_____ SSN:_____

Insured Mailing Address:_____

Insured Date of Birth:_____ Best Contact Number:_____

Policy Number:_____ Claim Number (If Applicable):_____

GUARANTOR'SINFORMATION **Please include your information if you are checking in a patient younger than 18 years old.*

First Name: _____ Last Name:_____

Date of Birth: _____ SSN:_____ Phone Number:_____

Address: _____

Street Address *City/State/Zip Code*

Print Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ **Date:**_____