MOTOR VEHICLE ACCIDENT/THIRD PARTY LIABILITY DATA

Martin Lopez M.D.

TODAY'S DATE: _____

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF INJURY: _____ TIME OF INJURY: _____

SEND BILL TO: _____

_____

_____

ADJUSTER/AGENT: _____ PHONE NUMBER: _____

RESPONSIBLE PARTY: _____ ADDRESS: _____
(WHO CAUSED)

_____

_____

_____

CLAIM NUMBER: _____

DO YOU HAVE AN ATTORNEY? YES NO

DOES THE OTHER PARTY HAVE AN ATTORNEY? YES NO

ATTORNEY'S NAME: _____ ATTORNEY'S NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

_____ _____

IF YOU DO NOT HAVE AN ATTORNEY AT THIS TIME, BUT DO GET ONE AT A LATER DATE, YOU MUST NOTIFY OUR OFFICE IMMEDIATELY. 405- 631-0300

My signature indicates that the above information is true and correct and I understand that I am fully responsible for any balance not paid for services rendered. I also understand that if payment is denied by the above mentioned parties, I will personally be responsible for the full amount charged for all services rendered.

In addition, a lien may be filed toward the proceeds of any monies issued toward settlement of my claim.

SIGNATURE: _____ DATE: _____