

**PERSONAL LIABILITY / MOTOR VEHICLE
SUPPLEMENTAL REGISTRATION FORM**

PATIENT INFORMATION

Name:	Account Number:
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Person or persons allegedly responsible for your injuries:

Name:		
Address:		
City:	State:	Zip Code:

Name:		
Address:		
City:	State:	Zip Code:

Are you represented by an attorney in your claims? _____ If Yes, please complete this section

Attorney:		
Law Firm:		
Address:		
City:	State:	Zip Code:
Phone () -	Facsimile () -	

Is the Alleged Responsible Party represented by an attorney in your claims? _____ If Yes, please complete this section

Attorney:		
Law Firm:		
Address:		
City:	State:	Zip Code:
Phone () -	Facsimile () -	

In the event your medical claims are to be submitted to a group health plan for injuries sustained in a personal liability / motor vehicle injury you may be responsible for deductibles, co-payments or coinsurance, depending upon the plan design.

X	Date
Patient / Guardian Signature	Date