



NO FAULT QUESTIONNAIRE

Name: _____

Address: _____

Phone #: _____

Your Local Agent: _____

Driver's Name: _____

Driver's Address: _____

Date of Accident: _____

Address where accident occurred: _____

Was alcohol a factor in this accident? _____

If yes, please specify _____

Driver's No Fault Insurance Company: _____

No Fault Insurance Company Address: _____

No Fault Insurance Company Phone #: _____

Did patient present to ER? _____

Was the patient hospitalized? _____

Were X-Rays taken? _____

Claim #: _____

DOB: _____

SS #: _____

I accept financial responsibility and promise to pay for all charges billed by Excel Physical Therapy to this account.

Signature: _____

Date: _____