

Accident Questionnaire



In order to update our records and complete claims processing, we are asking that you complete this questionnaire concerning your injuries.

Thank you for assisting our efforts in providing quality service.

2BWell Clinic
5935 Willow Lane
Lake Oswego, OR
97035
Phone: (503) 655 - 0044
Fax: (503) 515 - 8099
www.2bwell.net

Date:	
Injured Party:	
Member ID #:	
Date of Occurrence:	

Briefly describe the cause of injury: (e.g., location of accident/how it happened)

Name of other insurance company: (e.g., auto, homeowners', workers' comp)	
Insurance company address:	
Insurance company phone number:	
Policy holder name:	
Policy #:	
Claim #:	

If you have retained an attorney, please provide the following information:

Attorney name:	
Address:	
Phone number:	

Identity of other parties who may be responsible for the injuries:

Name:	
Address:	
Phone number:	

Name of insurance company: (e.g., auto, homeowners', workers' comp)	
Insurance company address:	
Insurance company phone number:	
Policy holder name:	
Policy #:	
Adjuster name:	
Claim #:	

Member Signature:	<div style="border: 1px solid black; width: 300px; height: 20px;"></div>	Date:	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>
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