

## Patient Information

| Personal Information |                             |                |                            |
|----------------------|-----------------------------|----------------|----------------------------|
| First Name           | EMILY                       | Middle Name    | -                          |
| Last Name            | EDWARDS                     | D.O.B          | 01/24/2003                 |
| Gender               | Female                      | Address        | 423 SOUTH FULLTON AVE APT3 |
| City                 | MOUNT VERNON                | State          | NEW YORK                   |
| Cell Phone #         | 347-206-6391                | Home Phone     | 718-881-5845               |
| Work                 | -                           | Zip            | 10553                      |
| Email                | -                           | Extn.          | -                          |
| Attorney             | DOMINICK LAVELLE            | Case Type      | No-Fault                   |
| Attorney Address     | 100 HERRICKS ROAD SUITE 201 | Attorney Phone | 800-745-4878               |
| Case Status          | OPEN                        | SSN            | -                          |

| Insurance Information |                 |              |                     |
|-----------------------|-----------------|--------------|---------------------|
| Policy Holder         | -               | Name         | LIBERTY MUTUAL INS. |
| Address               | P.O. Box# 1052  | City         | Montgomeryville     |
| State                 | PENNSYLVANIA    | Zip          | 18936-1052          |
| Phone                 | 800 245-1700    | Fax          | -                   |
| Contact Person        | -               | Claim File # | 034381648           |
| Policy #              | AOS228001979405 | WCB Group    |                     |

| Accident Information |            |                    |           |
|----------------------|------------|--------------------|-----------|
| Accident Date        | 09/14/2016 | Plate Number       | -         |
| Report Number        | -          | Address            | -         |
| City                 | -          | State              | -         |
| Hospital Name        | -          | Hospital Address   | -         |
| Date of Admission    | -          | Additional Patient | -         |
| Describe Injury      | -          | Patient Type       | Passenger |

| Employer Information    |   |         |   |
|-------------------------|---|---------|---|
| Name                    | - | Address | - |
| City                    | - | State   | - |
| Zip                     | - | Phone   | - |
| Date of First Treatment | - | Chart # | - |

| Adjuster Information |   |       |   |
|----------------------|---|-------|---|
| Name                 | - | Phone | - |
| Extension            | - | Fax   | - |
| Email                | - |       |   |