

DR. ROBERT'S MEDICAL CENTER

9349 Oak Street
Bellflower, CA 90706
(562) 920-6070

Full Name: _____ D.O.B.: _____ Date: _____

Do you have auto insurance? YES NO

If Yes, which car insurance?

Did the other car have auto insurance? YES NO

Do you have health insurance? YES NO

If Yes, what health insurance? GIVEN YES NO

Usted tiene seguro de carro? SI NO

Si tiene, cual es el nombre?

Tenia el carro que le atropello seguro? SI NO

Usted tiene seguro de salud? SI NO

Si tiene, cual es el nombre?
