



ALLIANCE COLLISION

CUSTOMER INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____ HOME PHONE: _____

_____ ALTERNATE PHONE: _____

CITY: _____ E-MAIL ADDRESS: _____

STATE: _____ ZIP CODE: _____

VEHICLE INFORMATION

YEAR: _____ MAKE: _____ MODEL: _____ LICENSE#: _____

We request this information so that we will be able to provide the best possible customer service and quality repair.

1. How did you hear about our company? (Please check one)

- | | |
|--|--|
| <input type="checkbox"/> Repeat Customer | <input type="checkbox"/> Insurance Company _____ |
| <input type="checkbox"/> Drive-In | <input type="checkbox"/> Auto Dealer _____ |
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Referred to me by _____ |
| <input type="checkbox"/> Insurance Agent | <input type="checkbox"/> Other _____ |

2. Who is paying for this repair? My Insurance Their Insurance Myself

3. Can we assist you in processing your insurance claim? Yes No

4. Name of Insurance Company paying for repairs. _____

Agent's Name _____ Phone _____

Claim Number _____ Policy Number _____

5. Has the Insurance Company inspected your vehicle and written a Damage Report? Yes No

6. Will you need a rental car? Yes No

7. What is your major concern in having your vehicle repaired?

Writer _____