

COASTAL BODY WORKS

QUALITY COLLISION REPAIR SINCE 1954

Damage Report Information

Name:	Email:	
Address:	City, State	Zip
Work Phone: () -	Home Phone: () -	Cell Phone: () -
Vehicle Year:	Make:	Model:
Your Insurance Company (write "Customer Pay" if not going through insurance):		
Policy Number:	Claim Number:	
Other Driver's Insurance Company (if applicable):		
Date of Loss:		

1) How did you hear about our shop?

- Repeat Customer
 Insurance Referral
 Agent Referral
 Past Customer Referral
 Yellow Pages
 Coastalbodyworks.com
 Driving By
 Other: _____

2) Do you need assistance with processing an insurance claim?

- Yes
 No

3) Other Questions/Concerns:
