MOTOR VEHICLE ACCIDENT INSURANCE - Patient Information

Patient's Name: _____
(surname) (first name)

Name of Policy Holder: _____
(surname) (first name)

1. Have you informed your adjuster that you are receiving chiropractic treatment? _____
2. Have you received your Accident Benefit Package? Yes ____ No ____
3. Did you complete it and send it to your Insurance Company? Yes ____No ____
4. Date of Accident: _____ Location: _____
5. Did you receive medical attention? _____ If yes, doctor's name: _____
6. Did you require ambulance or hospital services? _____

Description of accident:

(please print) _____ _____

_____

_____

_____

Motor Vehicle Accident Insurance Company

Insurance Company Name: _____

Address: _____

Phone #: _____

Policy #: _____ Claim #: _____

Adjuster's Name: _____ Phone #: _____

Extended Health Benefits(from either your work or your spouse's work)

Insurance Company Name: _____ Telephone # _____

Mailing address _____

Subscriber's Name _____ Date of Birth _____

Policy/Group # _____ ID/ Certificate # _____

If at any time this claim is denied by the insurance provider, it is the responsibility of the patient to cover the costs.

_____ _____

SIGNATURE **DATE**

_____

Signature of Guardian (if under 18 years old)