FRONTIER CHIROPRACTIC

Dr. Steven M. Henderson, D.C.

AUTO INJURY INFORMATION

PATIENT NAME:	DATE OF INJURY:

WAS THE VEHICLE YOU WERE IN AT FAULT ? ◙ YES ◙ NO

WERE YOU THE DRIVER? ◙ YES ◙ NO

YOUR INSURANCE INFORMATION: (Regardless of fault this must be complete)

Insurance Company Name: _____

Insurance Company Phone: _____

Address: _____

_____

Adjuster's Name: _____

Phone # _____ FAX# : _____

CLAIM NUMBER:		

OTHER PARTY INSURANCE INFORMATION: (If applicable)

Insurance Company Name: _____

Insurance Company Phone # _____

Address: _____

City _____ State _____ Zip _____

Adjuster's Name: _____

Phone # _____

CLAIM NUMBER:		

Have you retained an Attorney? ◙ YES ◙ NO

Attorney Name? _____

Attorney phone # _____

MED PAY	AMOUNT	Have you spent any of your MED PAY amount already? If yes, where and how much?
	$	