SUPERIOR SPINE CARE
CHIROPRACTIC MASSAGE REHABILITATION

PERSONAL INJURY INSURANCE MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Patient's Auto Insurance Company

Auto Insurance Company _____

Address _____

City, State, Zip _____

Policy # _____ Claim # _____

Agent's Name _____

Phone # _____ Fax # _____

Actively Covered _____

For Office Staff to Complete

Adjuster's Name_____

Phone # _____ Fax # _____

Uninsured Motorist Coverage _____ Medical _____

Notes _____

_____

Patient's Primary Health Insurance Company

Health Insurance Company _____

Address _____

City, State, Zip _____

Policy # _____ Group # _____

Deductible _____ Co-Payment _____

Patient Name _____ Date of Injury _____

SUPERIOR SPINE CARE
CHIROPRACTIC MASSAGE REHABILITATION

Patient's Secondary Health Insurance Company

Health Insurance Company _____

Address _____

City, State, Zip _____

Policy # _____ Group # _____

Deductible _____ Co-Payment _____

Vehicle Owner's Auto Insurance Company (If other than yourself)

Auto Insurance Company _____

Address _____

City, State, Zip _____

Policy # _____ Claim # _____

Agent's Name _____

Phone # _____ Fax # _____

Actively Covered _____

For Office Staff to Complete

Adjuster's Name_____

Phone # _____ Fax # _____

Uninsured Motorist Coverage _____ Medical _____

Notes _____

_____

Patient Name _____ Date of Injury _____

SUPERIOR SPINE CARE
CHIROPRACTIC MASSAGE REHABILITATION

Faulted Party's Auto Insurance Company

Auto Insurance Company _____

Address _____

City, State, Zip _____

Policy # _____ Claim # _____

Agent's Name _____

Phone # _____ Fax # _____

Actively Covered _____

For Office Staff to Complete

Adjuster's Name_____

Phone # _____ Fax # _____

Uninsured Motorist Coverage _____ Medical _____

Notes _____

_____

Patient Name _____ Date of Injury _____