ACTION CHIROPRACTIC

Automobile Accident Information

Patient Name: _____ Date of Birth: _____

Date of Accident: _____

Auto Insurance Company: _____

Medical Insurance Company: _____

Is Auto Insurance or Medical Insurance Primary? _____

Claim Number: _____

Adjuster Name: _____

Adjuster Phone Number: _____

Insurance Address: _____

City: _____ State: ____ Zip code: _____

Patient Signature: _____ Date: _____