BACK 2 BACK CHIROPRACTIC
A Family Wellness Place

Personal Injury Information

Patient Name: _____

Date of Loss: _____

Responsible Party's Insurance: _____

Responsible Party's Policy #: _____

Claim Number: _____

Patient's Insurance: _____

Patient's Policy #: _____

Claim Number: _____

Does Patient Have Med Pay? Y N **Amount:** _____

Please circle whether you are providing adjuster or attorney information

Attorney/Adjuster Name: _____

Attorney/Adjuster Address: _____

Attorney/Adjuster Phone: _____

Attorney/Adjuster Fax: _____

We Need:

Signed Lien ☐ **Health Insurance Card** ☐
(Date Faxed: _____**)**

ID ☐ **Police Report** ☐