



Smith Chiropractic Center

PERSONAL INJURY INSURANCE INFORMATION

NAME OF INSURED: _____ PATIENT: _____

DATE OF ACCIDENT: _____ DATE OF BIRTH _____

POLICY #: _____ CLAIM#: _____

CLAIMS ADJUSTER: _____ EXTENSION: _____

PHONE: _____ DED _____ MED PAY YES OR NO

MAIL CLAIM TO: _____

ATTORNEY: _____ PHONE: _____

ATTORNEY ADDRESS: _____

EMPLOYER NAME: _____ PHONE: _____

SUPERVISOR NAME: _____

ADDRESS: _____
