Kingston West Family Chiropractic
dedicated to excellence in natural family health
Dr. Adrina K. Patterson D.C.

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Auto Insurance Form for Motor Vehicle Accident Information

Name:_____ **Date:** _____

Date of Birth _____

Accident Date: _____

Have you seen any other health care providers concerning this accident? _____

If yes, whom? _____

Has a treatment plan been submitted to the auto insurance company?_____

Auto Insurance Company:_____

Name of Plan/Policy Holder:_____

Policy #:_____ Claim #:_____

Adjudicator's Name_____

City or Branch office of adjudicator_____

Adjudicator's Phone #: _____

Adjudicator's Fax #: _____

Adjudicator's email address if available:_____

Please describe the accident in your own words: _____

_____

_____

_____

_____