MOSIER/TIMPERLEY CHIROPRACTIC CLINIC
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Auto Related Injury

Name:_____ Date of Accident:_____

Time of Accident:_____A.M/P.M Is there a Police Accident Report? (Yes/No)

Location of Accident: _____

What is your Auto Insurance? _____ Phone:_____

Who is the primary cardholder? _____ Phone: _____

Who is your claims adjuster? _____

Your Policy #: _____Have you reported this to your Insurance Co.? (Yes/No)

Your Claim #:_____ Does your Insurance Co. know you are coming here? (Yes/No)

Other Parties Name:_____ Address:_____

Other Parties Insurance Co._____ Policy #:_____

Address:_____ Phone #:_____

Adjuster:_____ Claim #: _____

Do you have an Attorney? (Yes/No) if yes, Who? _____

Phone:_____ Address:_____

Signature: _____ Date:_____