Shepherd Chiropractic

AUTOMOBILE / PERSONAL INJURY CHECK LIST

Date:

Patient: _____

Insured: _____

Date of Injury: _____

Insurance Company Name & Address (Not Agency):

_____

_____

_____ Phone Number: _____

Adjustor: _____ Fax: _____

Claim #: _____

Policy #: _____

Attorney Name & Address:

_____

_____

_____ Phone Number: _____

Health Insurance Name & Address:

_____

_____

_____ Phone number: _____

ID#: _____ Group #: _____

I understand that I am directly and fully responsible for all medical services rendered to me.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

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