REQUIRED PERSONAL INJURY FORMS

Contact Information

Please print all information.

Patient Name (please print): _____

_____ **At Fault Insurance Information**

Insurance Company Name: _____

Claim #: _____

Adjuster Name: _____

Phone Number: _____

_____ **Your Auto Insurance Information**

Insurance Company Name: _____

Claim #: _____

Adjuster Name: _____

Phone Number: _____

_____ **Attorney Information**

Firm Name: _____

Attorney Name: _____

Phone Number: _____

_____ **Health Insurance Information**
Need copy of your Insurance card.

_____ **Accident Report**
Need copy of Accident Report. Reports are typically released 48 hours after accident.

Signature below of Patient/Guardian indicates that you have read and accepted the above provisions.

_____
Signature of Patient or Guardian Date

_____
Printed Name

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage with the above listed company and assign directly to Straight Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Any balance due whether or not insurance pays is due within 60 days of release from care. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____Date _____

Print Name _____

Minor's Name (if applicable) _____

Your relationship to minor_____