AUTOMOBILE ACCIDENT QUESTIONAIRE

Please Answer All Questions Completely

Name: ____ Date:_____________________

Address: ____ City: ______________________

State: _______ Zip Code: ________ SEX: ________ Marital Status: _____________ Weight: _________

SS#: ________________________ DOB:___________________ Age:_________ Height: ___________

Home Phone #:_________________________________ Work Phone #:___________________________

Cell Phone #: __________________________________ Pager: ___________________________________

E- Mail Address: ____

Occupation: ____

Employer Name: ____

Address: ____

Insurance Information Responsible for this Claim

Name of Policy Holder: ____

Insurance Company: ____

Insurance Company Claims Address: ____

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Policy #: _____________________________________ Claims #: ___________________________________

Name of driver in the other vehicle: ____

Name of your adjustor: ________________________________ Phone #: ____________________________

Name of your attorney: ________________________________ Phone #: ____________________________

Primary Care Physician Information:

Name: ____

Address: ____

City: ___________________________ State: _________________ Zip: __________________________

Phone: ____________________________ Date of last visit :___________________________________

Emergency Contact Information:

Name: ____

Address: ____

City: ___________________________ State: _________________ Zip: __________________________

Home: _________________________________ Work: _______________________________________

Cellular Phone: __________________________ Relationship: _________________________________

Please read and Sign BOTH statements below: Thank You!

Patients or Authorization Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request the payment of benefits either to myself or the party who accept assignments.

Name: ____ Date: ___________________________

Insured's or Authorization Person's Signature:

I authorize payment of medical benefits to the undersigned physicians or supplier of services described above namely **Perinton Hills Chiropractic, P.C.**

Name: ____ Date: ___________________________