

Driver of other vehicle (if any)

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his name and address _____

You were heading ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

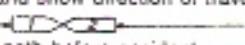
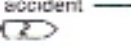




Other vehicle was heading ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

You were ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Using seat belts ☐ Other protective devices

<p>INDICATE ON THIS DIAGRAM WHAT HAPPENED</p> <p>USE ONE OF THESE OUTLINES TO SKETCH THE SCENE OF YOUR ACCIDENT, WRITING IN STREET OR HIGHWAY NAMES OR NUMBERS.</p> <ol style="list-style-type: none">1. Number each vehicle and show direction of travel by arrow: 2. Use solid line to show path before accident dotted line after accident: 3. Show pedestrian by: 4. Show railroad by: 5. Show distance and direction to landmarks; identify landmarks by name or number.6. Indicate north by arrow, as: 	<p>INDICATE NORTH BY ARROW</p> 
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I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

.....DO NOT WRITE BELOW THIS LINE.....

Patient accepted? ☐ Yes ☐ No Doctor's Signature: _____