AUTO INJURY:

- If auto accident, were you _____Driver _____Passenger _____Pedestrian
- If auto collision were you struck from _____Behind _____Front _____Left side _____Right side _____Auto was parked
- Did your car strike the other[s] involved? _____ Yes _____ No
  Or did the other car strike yours? _____ Yes _____ No Driver's Name_____
- As a result of the accident, were traffic citations issued to you? _____ Yes _____ No
  To the driver of the other car? _____ Yes _____ No
  To the driver of your car? _____ Yes _____ No

INSURANCE

If auto accident, your auto insurance carrier: _____
Address: _____
Phone: _____ Claim #:_____ Med pay: _____
Adjuster's Name[s]:_____

Other driver's auto insurance carrier: _____
Address: _____
Phone: _____ Claim#:_____ Med pay:_____
Adjuster's Name[s]: _____

Have you been contacted by an insurance adjustor or company representative regarding this claim?
If so, which company?_____
Status of claim?_____

Personal Health Insurance: _____
ID #: _____
Telephone #: _____ Fax #: _____

Do you have an attorney who has advised you in this case? _____ Yes _____ No
Name: _____
Address: _____
Telephone #: _____

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company that any amount authorized to be paid directly to this 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.

Signature: _____