SISK CHIROPRACTIC

AUTO ACCIDENT REPORT

NAME_____

ACCIDENT
DATE:_____TIME_____

DESCRIBE ACCIDENT IN DETAIL:_____
_____
_____

DESCRIBE YOUR SYMPTOMS IN DETAIL:_____
_____
_____

DID YOU REPORT THIS TO YOUR INSURANCE COMPANY? ____YES___NO

CLAIM #_____

NAME OF AUTO INSURANCE_____

IS THIS YOUR AUTO INSURANCE?_____

DID YOU FILL OUT AND SEND IN AN ***APPLICATION OF BENEFITS*** FORM?_____YES_____NO

INSURANCE COMPANY'S PHONE NUMBER:_____

INSURANCE COMPANY'S ADDRESS:_____
_____

CONTACT PERSON:_____

DO YOU HAVE AN ATTORNEY?_____YES_____NO

ATTORNEY'S NAME_____

HEALTH INSURANCE:_____YES_____NO

TYPE OF HEALTH INSURANCE_____

PLEASE PRESENT HEALTH INSURANCE CARD.

SIGNATURE:_____DATE:_____