KIGER STEFFES CHIROPRACTIC SC
PERSONAL INJURY PATIENT INFORMATION

Name_____ **Date**_____

YOUR Auto Insurance Carrier _____ **MEDPAY Amount** _____

Claim #_____ **Please verify you opened a claim for Medical Bills (not vehicle)**

Adjustor's Name_____ **Phone**_____

Mail Claims To_____

FAX # for Claims _____ ***Please fill in this information COMPLETELY.***

Are you represented by an attorney? YES NO

Attorney Name _____ Phone_____

Address_____

City, State, Zip_____

Time and date of injury_____ **am / pm** _____

Were you: DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER

Number of people in vehicle_____ Were you wearing a seat belt? YES NO

What direction were *you* headed? NORTH EAST SOUTH WEST At approx_____mph

On (name of street)_____

What direction was the *other vehicle* headed? NORTH EAST SOUTH WEST At approx_____mph

On (name of street)_____

Were you struck from: BEHIND FRONT LEFT SIDE RIGHT SIDE Were police notified? YES NO

Please explain in detail how your accident happened_____

_____

_____

Where did you feel pain *immediately after the accident*? _____

Were you unconscious? YES NO Are your *present* symptoms: Improving? Worse? Same?

Present symptoms _____

Does your condition interfere with any activities of daily living? YES NO If so, how?_____

_____

_____

I authorize the release of any medical or other information necessary to process this claim. I acknowledge that I am responsible for payment of charges incurred in the event my personal injury claim is denied. I authorize the billing of health insurance if benefits are available and assign payment to: Kiger Steffes Chiropractic, S.C.

Signature_____ Date_____