FRANCIS CHIROPRACTIC CLINIC, S.C.

Accidental Injury Insurance Company / Attorney Information

Name:_____Date:_____

I.

1. Name of my Health Insurance Company:_____
2. Address:_____
3. Phone:_____
4. Policy Holder's Name:_____
5. Policy Number:_____

II.

1. My Auto Insurance Company:_____
2. Address:_____
3. Phone:_____
4. Policy Holder's Name:_____
5. Policy Number or Claim Number:_____

III.

1. Responsible Party's Insurance Company:_____
2. Address:_____
3. Phone:_____
4. Policy Holder's Name:_____
5. Policy or Claim Number:_____

IV:

Do you have an Attorney? ☐ Yes / ☐ No

If yes, name of Attorney:_____

Address:_____

Phone:_____