WARWICK CHIROPRACTIC AND MASSAGE

8650 Martin Way E #207, Lacey WA 98516

PERSONAL INJURY CASE INFORMATION

DATE_____

FIRST NAME _____ LAST NAME _____

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____ AM / PM

LOCATION OF ACCIDENT _____

BRIEFLY DESCRIBE WHAT HAPPENED TO CAUSE YOUR INJURY _____

_____

_____

_____

HAVE YOU LOST TIME FROM WORK DUE TO THIS INJURY? YES / NO IF YES, DATES FROM _____ TO _____

YES / NO DO YOU HAVE AN ATTORNEY FOR THIS INJURY? IF YES: ATTORNEY NAME _____

ATTORNEY ADDRESS _____ ATTORNEY PHONE_____

PERSONAL INJURY PROTECTION (PIP) INSURANCE INFORMATION (YOUR AUTO INSURANCE):

PIP CLAIM NUMBER (THIS IS DIFFERENT THAN YOUR AUTO REPAIR CLAIM NUMBER)_____

CLAIM ADJUSTER'S NAME _____

CLAIM ADJUSTER'S TELEPHONE_____ CLAIM ADJUSTER'S FAX_____

NAME OF YOUR AUTO INSURANCE CARRIER _____

ADDRESS WHERE THEY WANT CLAIMS SENT_____

THIRD PARTY INSURANCE INFORMATION (THE AT FAULT PARTY'S AUTO INSURANCE):

THIRD PARTY CLAIM NUMBER _____THIRD PARTY CLAIM ADJUSTER'S NAME _____

THIRD PARTY CLAIM ADJUSTER'S TELEPHONE_____ FAX_____

NAME OF AT FAULT PARTY'S AUTO INSURANCE CARRIER _____

ADDRESS OF AT FAULT PARTY'S AUTO INSURANCE CARRIER _____

Full name_____Date_____

Signature_____