



IF YOU WERE THE **DRIVER**, OPERATING **YOUR OWN VEHICLE**, ANSWER THIS SECTION COMPLETELY

**Your Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_

Agency Name

**Your Health Insurance Company**

Name \_\_\_\_\_  
Policy# \_\_\_\_\_  
Group # \_\_\_\_\_  
Employer \_\_\_\_\_

IF YOU WERE DRIVING **SOMEONE ELSE'S VEHICLE**, ANSWER THIS SECTION COMPLETELY

**Your Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_

Agency Name City

**Your Health Insurance Company**

Name \_\_\_\_\_  
Policy# \_\_\_\_\_  
Group # \_\_\_\_\_  
Employer \_\_\_\_\_

**Vehicle Owner's Name**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Vehicle Owner's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_

Agency Name City

IF YOU WERE A **PASSENGER** IN THE VEHICLE, ANSWER THIS SECTION COMPLETELY

**Your Driver's Name**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Your Driver's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_

Agency Name

If driver was operating someone else's vehicle, also give:

**Vehicle Owner's Name**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Vehicle owner's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased

from \_\_\_\_\_  
Agency City

If you are a member of your household own a car:

**Your/Their Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from: Agent \_\_\_\_\_

If you have health insurance:

**Your Health Insurance Company**

Policy# \_\_\_\_\_  
Group # \_\_\_\_\_  
Employer \_\_\_\_\_

If **you** do not own a vehicle, but someone living at your permanent address **does**, give:

Their Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Their Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_

Agency City

IF ANOTHER VEHICLE WAS INVOLVED IN THE COLLISION, ANSWER THIS SECTION COMPLETELY

**Driver of other vehicle:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Other Driver's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_  
Agency City

If the driver was operating someone else's vehicle:

**Vehicle Owner's Name**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Vehicle Owner's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_  
Agency City

IF YOU WERE A PEDESTRIAN OR WERE RIDING A BICYCLE, ANSWER THIS SECTION COMPLETELY

**Driver with which you collided**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Driver's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_  
Agency Name

If the driver was operating someone else's vehicle

**Vehicle Owner's:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Vehicle Owner's Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_  
Agent City

If you own a vehicle, your Auto Insurance Company

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_  
Agent City

If you are covered by health insurance

**Your Health Insurance Company's**

Name \_\_\_\_\_  
Policy# \_\_\_\_\_  
Group # \_\_\_\_\_  
Employer \_\_\_\_\_

If you do not own a vehicle, but someone living at your permanent address does own a vehicle, give:

Their Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Their Auto Insurance Company**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Policy# \_\_\_\_\_  
Purchased from \_\_\_\_\_  
Agent City

THE FOLLOWING INFORMATION IS REQUIRED OF ALL PATIENTS:

Has this accident been reported to the police?  Yes  No  
If yes, did they come to the scene of the accident?  Yes  No  
If yes, did they cite anyone with a traffic violation?  Yes  No  
If yes, whom?  myself  my driver  the other driver

Have you reported this accident to any insurance company?  Yes  No

If yes, which one(s)?  my own  my driver's  the owner of my driver's vehicle  
 the other drivers  the owner of the other driver's vehicle

If a claim number has been assigned, please give \_\_\_\_\_  
Claim #

Have you retained the services of an attorney?  Yes  No

**If yes, Attorney's Name:**

Address

City State Zip

Telephone # ( ) -

Fax #

This information given in this questionnaire is true and accurate to the best of my knowledge.

Signed \_\_\_\_\_  \_\_\_\_\_ Date \_\_\_\_\_

THE STAFF OF THIS CHIROPRACTIC OFFICE APPRECIATES YOUR TAKING THE TIME TO GATHER THIS VITAL INFORMATION. PLEASE BE ASSURED WE WILL DO EVERYTHING POSSIBLE TO ASSIST IN YOUR RECOVERY. WE WILL ALSO MAKE EVERY EFFORT TO SECURE ANY COVERAGES THAT WILL ENABLE YOU TO RECEIVE WHATEVER CARE YOU MAY NEED.

THANK YOU FOR YOUR COOPERATION