Fort Wayne Chiropractic
Gregory J Hough, DC
4771 Trier Road, Fort Wayne, IN 46815

Auto Accident Insurance Coverage

Insured's Name: _____ Date of Accident: _____

Claim Number: _____ Policy Number: _____

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Telephone: _____ Adjusters Name: _____

Personal Health Insurance

Fill out this section if we will not be filing under your automobile insurance and will be filing through your personal insurance. If so, we need a copy of your insurance card(s) for our records

INSURANCE SUBSCRIBER INFORMATION: *If the subscriber is not the patient.*

Full Name _____ Date of birth _____/_____/_____

Relationship to patient _____ Social Security Number _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Attorney Information

Fill out this section if you have retained an attorney for your automobile accident claim.

Attorney Name/Firm: _____

Attorney Address: _____

Attorney Telephone: _____ Fax Number: _____

I agree that the information above is correct.

_____ _____

Date Patient/Responsible Party Signature