GLASGOW SPINE & WELLNESS
WILMINGTON SPINE CENTER

AUTO ACCIDENT CLAIM INFO

PATIENT: _____ DOB:_____

DATE OF ACCIDENT:_____**STATE WHERE THE ACCIDENT OCCURRED:**_____

Policyholder of the car you were in during the accident:_____

Relationship to the Policyholder:_____

Insurance Company:_____Claim#_____

Address:_____

Phone#:_____Fax #:_____

Claim Adjuster:_____Reported to Insurance Company? Yes / No

Claim Adjuster's E-mail:_____

Did anyone Receive a Ticket? ___Yes ___No If so who?_____

Personal Injury Protection (PIP Application) submitted to your medical claim's adjuster? ___Yes ___No

Have you contacted an Attorney? ___Yes___No

Attorney's Name:_____Phone:_____

Address:_____

PATIENT SIGNATURE:_____DATE:_____