

**GLASGOW SPINE & WELLNESS
WILMINGTON SPINE CENTER**

SLIP & FALL CLAIM INFO

PATIENT: _____ **DOB:** _____

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

Insurance Company: _____ **Claim#** _____

Address: _____

Phone#: _____ **Fax #:** _____

Claim Adjuster: _____ **Reported to Insurance Company?** Yes / No

Claim Adjuster's E-mail: _____

Have you contacted an Attorney? _____ Yes _____ No

Attorney's Name: _____ **Phone:** _____

Address: _____

SIGNATURE: _____ **DATE:** _____