Chiropractic Health Center of Parma
Insurance Information

PERSONAL INJURY INSURANCE/PAYMENT INFORMATION

Patient Name: ____ Date: _____________________

Date of Injury: ____________________________

AUTO INSURANCE (PATIENT)

Name of Patient's Car Insurance: ____ (Not Policy #)

Is there Medical Coverage? ☐ YES ☐ No

If Yes, complete the rest of the section. If No, go to Health Insurance Section.

Claim Number: ____ (Not Policy #)

Claim Adjuster: ____

Address for Claims Center: ____

Telephone Number: _______________________________________

AUTO INSURANCE (OTHER PARTY)

Other Party's Car Insurance: ____

Claim Number: ____ (Not Policy #)

Claim Adjuster: ____

Address for Claims Center: ____

Telephone Number: _______________________________________

HEALTH INSURANCE CARRIER (PATIENT)

Name of Carrier: ____

Policy Number: ___________________________________ Group Number: ____________________

Address for Claims Center: ____

Attorney

Name: ____ Phone Number: ____________________

Address: ____

*******Please give front desk any and all insurance cards to make copies for your file. Thanks!***