DeFalco Family Chiropractic

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Verification of Auto Claim Form

Today's Date: _____

Patient Name: _____

Name of YOUR Auto Insurance (PIP): _____ Date of Injury or Accident: __/___/____

Claim #: _____ In which state did accident occur: _____

PIP Adjustor's Name: _____ Phone #:_____

Fax: _____ Email: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Attorney Name & Firm: _____

Address (street, city, state, zip) _____

Attorney phone & email: _____

Health Insurance Information

Your claim for personal injury protection benefits may be coordinated with your own personal health insurance per MGL c90, Section 34M.

Are you eligible for coverage under any health insurance plan? ( ) YES ( ) NO

Please provide a copy of your health insurance card to keep on file.

Health Insurance Plan: _____Member ID #_____

Signature _____

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Automobile Accident Injury Information:

Date:_____

Patient Name:_____ Patient Struck as a Pedestrian:_____

Date of Accident:_____ Time:_____ AM/PM

Pt. Speed was: Stopped Accelerating Slowing Constant Road Conditions:_____

Pt. Vehicle:_____ Other Vehicle:_____

Where was Vehicle Struck:_____ Where Pt. was Sitting:_____

Airbags Deployed: YES / NO Seat Break: YES / NO Aware prior to Impact: YES / NO
Seatbelt: YES / NO Brake On: YES / NO Head Restraint: YES / NO

Hand Position at Impact:_____ Body Position at Impact:_____
Head Position at Impact:_____ Loss of Consciousness:_____

Where did you go after the accident: ER / MD / DC / Work / Home If MD what kind:_____
How did you get there: Self / Friend / Ambulance Time Missed from Work:_____
Treatments Receive:_____

Location of Accident:_____
_____

Police at Crash Site: YES / NO Police Report: YES / NO

Estimated Damage to Pt. Vehicle:_____ Other Vehicle:_____

Attorney:_____ Phone:_____

Description of Accident:

_____
_____
_____
_____
_____
_____