

**FRANCIS CHIROPRACTIC CLINIC, S.C.**  
**Accidental Injury Insurance Company / Attorney Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

I.

1. Name of my Health Insurance Company: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Phone: \_\_\_\_\_
4. Policy Holder's Name: \_\_\_\_\_
5. Policy Number: \_\_\_\_\_

II.

1. My Auto Insurance Company: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Phone: \_\_\_\_\_
4. Policy Holder's Name: \_\_\_\_\_
5. Policy Number or Claim Number: \_\_\_\_\_

III.

1. Responsible Party's Insurance Company: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Phone: \_\_\_\_\_
4. Policy Holder's Name: \_\_\_\_\_
5. Policy or Claim Number: \_\_\_\_\_

IV:

Do you have an Attorney?       Yes /  No

If yes, name of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_