DAVIS CHIROPRACTIC

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Please have the following information completed prior to your initial exam, as it is required in order to process your claims for services rendered.

Patient Name _____

Date _____

Type of Accident (Circle One): Work Auto Personal

Claim Number _____

Date of Accident _____

Your Insurance Company: *(Where Claims Will Be Submitted)*

Name _____
Address _____
_____
Phone # _____

Your Adjuster's:
Name _____
Phone # _____