ERIE COUNTY CHIROPRACTIC
backing buffalo since 1996

Last Name_____ First Name_____ M.I. _____

Street_____City _____State_____Zip_____

Home Phone#_____ Work Phone#_____

SS#_____ Date of Birth_____ Sex_____ Marital Status _____

Email Address_____ Employer_____

Street_____City_____State_____Zip_____

May we send you correspondence via the above e-mail address? ☐No ☐Yes
May we put your name on our Birthday List? ☐No ☐Yes

In case of an emergency, whom should we contact (Name & Phone#)?

_____

ACCIDENT INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. (For the vehicle you were in at the time of the accident.)

Date of Accident: _____

Insurance Company_____Phone#_____

Street _____ City _____ State_____ Zip Code _____

Adjuster_____ Phone#_____

Policy#_____ Claim#_____ File#_____

Name of Policyholder_____ Your Relation to the insured_____

Did you report the accident to **your** insurance company? ☐No ☐Yes

Did you submit the "**Application of no-fault Benefits**" to your insurance company? ☐No ☐Yes

SECONDARY INSURANCE

Insurance Company_____Phone#_____

Policy#_____ Claim#_____ File#_____

Name of Policyholder_____ Your Relation to the insured_____

*If you have received medical attention for this injury, please list names and phone numbers below.

Name/Phone_____ Name/Phone _____

Patient's Signature_____ Date _____