Chiropractic Associates, Inc.

MEDICAL PAYMENT INSURANCE QUESTIONNAIRE

Patient Name ________________________________ **Date** ____________________

IF YOU WERE THE **DRIVER**, OPERATING **YOUR OWN VEHICLE**, ANSWER THIS SECTION **COMPLETELY**

Your Auto Insurance Company

Name
Address
City, State, Zip
Policy #
Purchased from
Agent's Name City
Phone #

Your Health Insurance Company

Name
Address
City, State, Zip
Policy #
Group #
Phone #
Employer

IF YOU WERE **DRIVING SOMEONE ELSE'S VEHICLE**, ANSWER THIS SECTION **COMPLETELY**

Your Auto Insurance Company

Name
Address
City, State, Zip
Policy #
Purchased from
Agent's Name City
Phone #

Vehicle Owner's Name
Address
City, State, Zip
Phone #

Your Health Insurance Company

Name
Address
City, State, Zip
Policy #
Group #
Phone #
Employer

IF YOU WERE **A PASSENGER** IN THE VEHICLE, ANSWER THIS SECTION **COMPLETELY**

Your Driver's Name
Address
City, State, Zip
Phone #

If the driver was operating someone else's vehicle, ALSO give:

Vehicle Owner's Name
Address
City, State, Zip
Phone #

If you or a member of your household own a car:

You/Their Auto Insurance Company

Name
Address
City, State, Zip
Purchased from
Agent's Name City
Phone #

If you do not own a vehicle, but someone living at your permanent address does, give:

Their Name
Address
City, State, Zip
Phone #

Their Auto Insurance

Name
Address
City, State, Zip
Policy #
Purchased from
Agent's Name City
Phone #

Your Driver's Auto Insurance Company

Name
Address
City, State, Zip
Policy #
Purchased from
Agent's Name City
Phone #

Vehicle Owner's Auto Insurance Company

Name
Address
City, State, Zip
Policy #
Purchased from
Agent's Name City
Phone #

If you have health insurance:

Your Health Insurance Company

Name
Policy #
Group #
Address
City, State, Zip
Phone #
Employer

Chiropractic Associates, Inc.

IF **ANOTHER VEHICLE** WAS INVOLVED IN THE COLLISION, ANSWER THIS SECTION **COMPLETELY**

Driver of other vehicle

Name ______
Address ______
City, State, Zip ______
Phone # ______

Other Driver's Auto Insurance Company

Name ______
Address ______
City, State, Zip ______
Policy # ______
Purchased from ______
Agent's Name City
Phone # ______

If the driver was operating someone else's vehicle:

Vehicle Owner's Name ______
Address ______
City, State, Zip ______
Phone # ______

Vehicle Owner's Auto Insurance Company

Name ______
Address ______
City, State, Zip ______
Policy # ______
Purchased from ______
Agent's Name City
Phone # ______

IF YOU WERE **A PEDESTRIAN** OR WERE **RIDING A BICYCLE**, ANSWER THIS SECTION **COMPLETELY**

Driver with whom you collided

Name ______
Address ______
City, State, Zip ______
Phone # ______

Driver's Auto Insurance Company

Name ______
Address ______
City, State, Zip ______
Policy # ______
Purchased from ______
Agent's Name City
Phone # ______

If the driver was operating someone else's vehicle:

Vehicle Owner's Name ______
Address ______
City, State, Zip ______
Phone # ______

Vehicle Owner's Auto Insurance Company

Name ______
Address ______
City, State, Zip ______
Policy # ______
Purchased from ______
Agent's Name City
Phone # ______

If you own a vehicle, your Auto Insurance Company

Name ______
Address ______
City, State, Zip ______
Policy # ______
Purchased from ______
Agent's Name City
Phone # ______

If you are covered by health insurance

Your Health Insurance Company
Name ______
Address ______
City, State, Zip ______
Policy # ______
Group # ______
Phone # ______
Employer ______

If you do not own a vehicle, but someone living at your permanent address does, give:

Their Name ______
Address ______
City, State, Zip ______
Phone # ______

Vehicle Owner's Auto Insurance Company

Name ______
Address ______
City, State, Zip ______
Policy # ______
Purchased from ______
Agent's Name City
Phone # ______

______
Patient (or Guardian) Signature

______
Date

Print name ______