Optimal Wellness Chiropractic Center

Personal Injury Form

Personal Information:

First Name: Last Name: Middle Initial:

Address: City, State Zip:

Home Phone: Work Phone: Cell Phone:

Email: Are you interested in receiving a newsletter? ☐ Yes ☐ No

Date of Birth: Age: Height: Weight:

Dominant Hand: ☐ Right ☐ Left ☐ Both

Occupation: Employer: Employer's Address:

Name of your Medical Doctor: Phone #:

May we communicate our findings with your Medical Doctor: ☐ Yes ☐ No

Have you had to miss work due to the injury/onset? ☐ Yes ☐ No

If yes, what dates?

Have you been contacted by an Insurance Adjuster regarding your claim?: ☐ Yes ☐ No

If yes, what is the name of your Insurance Adjuster?

and Company

What is their Address? Phone #

What is your Claim#? Fax #

Have you retained an Attorney to represent you in your Personal injury?: ☐ Yes ☐ No

If yes, who is your Attorney?

What is their Address? Phone #:

Fax #:

If you have an attorney, will they be submitting your Med-Pay claim or would you like us to submit this for you?

In the event of an Emergency, whom should we notify? Relation To Patient: Daytime Phone:

Please provide the receptionist with your Driver's License so it can be photo copied.

Please sign name on each page Date

Submit Form