Mack Chiropractic Health Center
Dr. Patrick C. Mack DC PC

Please complete this questionnaire **ONLY IF** you are seeking treatment due to an **auto** or **work related accident**

1. Name: (Please Print) ______________________________

2. Date of accident: ______________

3. Type of accident: (circle) auto / workers comp.

4. Are you unable to work due to this injury? Y / N

5. Patient was the: ___ Driver ___ Passenger ___ Pedestrian ___ Other

6. Insurance company claims should be sent to: ______________________________

7. Adjusters name: ______________________________

   Phone # : ______________________ ext. ______________

8. Claim number: ______________________________

9. Policy number: ______________________________

10. Did you file a Report of Injury? Y / N ... If NO, do you intend to file a claim? Y / N

11. Have you settled your claim? Y / N

12. If YES, with whom did you settle? ______________________________

13. Attorney name: (if applicable) ______________________________

14. Phone # : ______________________________

15. Please describe how and where the accident took place: ______________________________

____

____

____

____