

Will you be paying for the visits yourself, or would you like this billed through your Health Insurance? \_\_\_\_\_

Insurance company name \_\_\_\_\_

Address \_\_\_\_\_

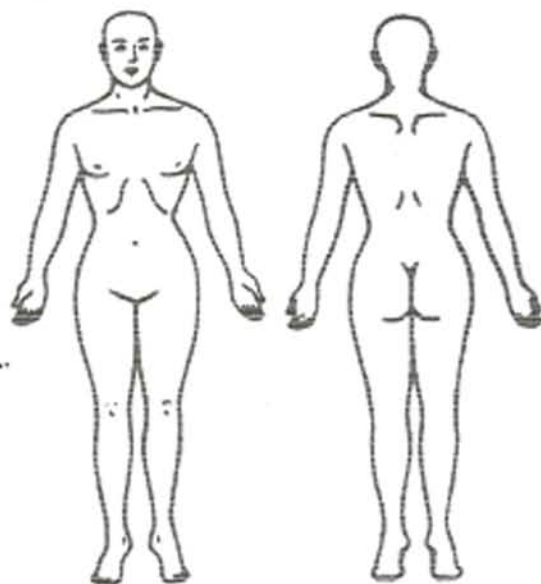
Certificate Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is this an injury due to Automobile Accident or a work related accident? \_\_\_\_\_

Do you have a lawyer regarding your accident? Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Please mark areas of pain or injury on the illustrations below  
and give a word description of the symptoms you are  
experiencing in those areas:



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Signature \_\_\_\_\_

Date \_\_\_\_\_