Allure Wellness and Rehab, L.L.C.

NAME-		DOB-		TODAY'S DATE -		DATE OF INJURY-	
CELL PH-		HOME PH-		WORK PH-		E-MAIL-	
ADDRESS-		CITY-		STATE-		ZIP CODE-	

YOUR AUTO INS CO. Allstate, State Farm, Geico, Prudential, Progressive, USAA, Farmers, Fred Loya, Old American County Mutual, Travelers, Liberty Mutual, Nationwide

Other: _____ POLICY # _____ CLAIM # _____

Year, Make And Model of your vehicle- _____

3rd PARTY INS CO. Allstate, State Farm, Geico, Prudential, Progressive, USAA, Farmers, Fred Loya, Old American County Mutual, Travelers, Liberty Mutual, Nationwide

Other: _____ POLICY # _____ CLAIM # _____

Year, Make And Model of THEIR vehicle- _____

IF YOU WERE A PASSENGER, WHAT IS THE NAME OF THE DRIVER OF THE CAR IN WHICH YOU WERE INJURED? _____

NAME OF YOUR INSURANCE ADJUSTOR _____

NAME OF 3RD PARTY INSURANCE ADJUSTOR _____

HAVE YOU RETAINED AN ATTORNEY? _____YES _____NO NAME OF ATTORNEY _____

Please circle the name of your health insurance : CIGNA UHC BC/BS AETNA PHCS HUMANA TEXAS1st HEALTH PACIFICARE GREAT WEST FOCUS

OTHER _____SUBSCRIBER ID # / GROUP # _____CARD NUMBER _____

PLEASE EXPLAIN IN DETAIL HOW YOUR ACCIDENT HAPPENED _____

_____

_____

HAVE YOU MISSED WORK AS A RESULT OF THE INJURY? _____ HOW MANY DAYS HAVE YOU MISSED? _____

********** *DID THIS ACCIDENT OCCUR WHILE YOU WERE ON THE JOB OR WERE YOU IN A COMPANY VEHICLE* YES NO **********

YOU WERE HEADING _____NORTH _____SOUTH _____EAST _____WEST ON _____(STREET/HIGHWAY)

OTHER VEHICLE WAS HEADED _____NORTH _____SOUTH _____EAST _____WEST ON_____(STREET/HIGHWAY)

WERE POLICE NOTIFIED? _____YES _____NO WERE YOU HIT BY A DRUNK DRIVER? _____ YES _____ NO

WERE YOU KNOCKED UNCONSCIOUS? _____YES _____NO IF SO, FOR HOW LONG? _____

YOU WERE STRUCK FROM _____BEHIND _____ FRONT _____ LEFT SIDE _____ RIGHT SIDE

YOU WERE _____DRIVER _____PASSENGER _____FRONT SEAT _____BACK SEAT _____USING SEAT BELTS _____ OTHER PROTECTIVE DEVICES

WHERE DID YOU FEEL PAIN IMMEDIATELY AFTER THE ACCIDENT? _____

WHICH HOSPITAL WERE YOU TAKEN TO? _____

WHAT DID THEY DO? _____

DID YOU SEEK OTHER MEDICAL CARE? _____ DOCTOR'S NAME AND NUMBER_____

HAVE YOU EVER HAD ANY COMPLAINTS IN THE INVOLVED AREA BEFORE? _____YES _____NO

IF SO, WHAT WERE THE COMPLAINTS? _____

BEFORE THE INJURY, WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR AGE? _____YES_____NO

ARE YOUR WORK ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT? _____ YES _____ NO

SINCE THIS INJURY, ARE YOUR SYMPTOMS _____ IMPROVING? _____ GETTING WORSE? _____ SAME?

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION OF FALSE CLAIM, INCOMPLETE OR MISLEADING INFORMATION WILL BE REPORTED TO THE TEXAS DEPARTMENT OF INSURANCE.

IN ORDER TO ASSURE YOUR CLAIM IS VALID OUR CLINIC REQUIRES A COPY OF YOUR POLICE REPORT.

DO YOU HAVE A COPY?_____ YES _____ NO

I, _____, AM NOT FILING A FALSE CLAIM OR A CLAIM AS A RESULT OF A STAGED ACCIDENT.

PATIENT/GUARDIAN SIGNATURE_____DATE _____

DOCTOR SIGNATURE _____DATE _____

PATIENT SIGNATURE OR LEGAL GAURDIAN TO PATIENT	DATE:
DOCTOR SIGNATURE ATTESTING	DATE: