PANAIA CHIROPRACTIC & REHABILITATION
OF CHERRY HILL, LLC
1299 BRACE ROAD
CHERRY HILL, NJ. 08034
PHONE 856-795-2424
FAX 856-795-2212

PIP PATIENT INFORMATION FORM

PATIENT NAME: ______________________________ D/A: ______________

INSURED NAME: ______________________________

DATE OF START TREATMENT: ______________________________

CLAIM NUMBER: ______________________________

POLICY NUMBER: ______________________________

INSURANCE CO NAME: ______________________________

INSURANCE CO ADDRESS: ______________________________

____

INSURANCE CO PHONE #: ______________________________

INSURANCE CO FAX: ______________________________

ADJUSTER NAME: ______________________________

ADJUSTER PHONE #: ______________________________

CASE MANAGER AND PHONE #: ______________________________

ATTORNEY NAME: ______________________________

ATTORNEY ADDRESS: ______________________________

____

ATTORNEY PHONE #: ______________________________

Name: ______________________________ Date: ___________________________

Address: ____

Birthdate: ______________________ Date of Accident: ______________________

Auto Accident__________________, or Slip/ Fall Accident__________________

If Auto Accident: Driver _____, Passenger______, Front Seat______, Rear Seat______

Were you wearing a seatbelt?	Yes ______	No______	N/A______
Did the airbag go off?	Yes ______	No ______	N/A______
Did you hit your head?	Yes ______	No ______	N/A ______
Did you lose consciousness?	Yes ______	No ______	N/A ______
Did you get dizzy following the impact?	Yes______	No______	N/A______
Headaches / nausea?	Yes ______	No______	N/A ______
Damage to any body part?	Yes ______	No ______	N/A ______

Is yes, please name? ____

Any damage to knee / shoulder / wrist?	Yes ______	No ______	N/A ______

If yes, please name? ____

Fractures or Abrasions?	Yes ______	No ______	N/A ______

If yes, please name? ____

Was there an ambulance at the scene?	Yes ______	No ______	N/A______
Did you: Accept ______ Deny______	ambulance?		N/A ______
Did you go to the hospital?	Yes ______	No ______	N/A ______

If yes, please name the hospital? ____

If yes, how did you get there? ____

Did you have any tests / x-rays done?	Yes ______	No_______	N/A ______

If yes, what kind and where? ____

Did you see any other doctors?	Yes ______	No ______	N/A ______

If yes, please name, address, and number?

____

Did you file an accident report?	Yes ______	No ______	N/A ______
If yes, do you have a copy?	Yes ______	No______	N/A ______
Are you taking any medications?	Yes ______	No ______	N/A ______

If yes, please name? ____