Complete Health
Chiropractic Center, LLC

Tel: (503) 557-9266
Fax: (503) 557-9220
365 Warner Milne Rd., Suite 105, Oregon City, OR 97045
E-mail: info@completehealthcc.com
completehealthcc.com
Find us on facebook

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full legal name:		Date:
Address:		
City:		State: Zip:
Cell phone:	Home phone:	Work phone:
Email address:	Date of Birth:	Age:
☐ Male ☐ Female ☐ _____	Pregnant? Yes ☐ No ☐	
Height: Weight:	Number of children:	Ages of children:
Driver's license number:		
Occupation:	Employer's name:	
Relationship status: Single Married Partnered Widowed Divorced		
Partner's/spouse's name:	Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? Yes ☐ No ☐ Insurance Company Name:	Do you have Medicare coverage? Yes ☐ No ☐	
Emergency contact name and number:	Emergency contact relationship to you:	

Whom may we thank for referring you? _____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns in order of severity:

Rate the health concern from 0 -10
0 = no pain 10 = the worst pain possible

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Did any of these problems begin with an injury?_____ Date of injury:_____
Which problems began with the injury?_____

Since the problem(s) started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

Which activities aggravate your condition? _____

Have you seen other doctors for this condition?
If yes, please list doctors you have seen and when: _____

Is this condition interfering with any of the following:

Work ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐ Other ☐ (please explain):

General Health History

Operations: Surgical interventions, which may or may not have included hospitalization. _____ **NONE**

Type of surgery:	**Date:**

Injuries: Have you ever... _____**NONE**

	Date:
__ Had a fractured bone	
__ Had a spine or nerve disorder	
__ Been knocked unconscious	

__ Been injured in an accident: **(auto, work- related or other?)** Please list type and when: _____

Family History: Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	**Age (if living)**	**State of health** Good	Poor	**Illnesses**	**Age at death**	**Cause of death**
Mother						
Father						
Sister 1						
Sister 2						
Brother 1						
Brother 2						

Social History: Tell us about your health habits and stress levels.

Alcohol use	__None __ Daily __ Weekly How much? _____	Prayer or meditation?	__Yes __No
Coffee use	__ None __ Daily __ Weekly How much? _____	Job pressure/stress?	__Yes __No
Tobacco use	__ None __ Daily __ Weekly How much? _____	Financial peace?	__Yes __No
Exercising	__ None __ Daily __ Weekly How much? _____	Vaccinated?	__Yes __No
Pain relievers	__ None__ Daily __ Weekly How much? _____	Mercury fillings?	__Yes __No
Water intake	__ Daily __ Weekly How much? _____	Recreational drugs?	__Yes __No

Hobbies: _____

Have you ever had chiropractic care? __ No __ Yes
If yes, whom did you see? _____
When did you see the chiropractor and for how long? _____

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Current Medicines and Supplements

Please list any **medications/drugs** you have taken in the past 6 months **and why**: (prescription and non-prescription) ___ NONE

_____

Please list all **nutritional supplements, vitamins, homeopathic remedies** you presently take **and why**: ___ NONE

_____

In the **past 3 years** have you had x-rays, an MRI or CT of your spine? ___ Yes ___ No If yes, When? _____ What? ____

Do you wear orthotics or heel lifts? Yes ☐ No ☐ Sleep positions: ___ Side ___ Back ___ Stomach

Review of Systems: Please mark the **"now" column** if you currently have the problem(s) listed below, and mark the **"past" column** if you had the problem in the past.

Now	Past		Now	Past	
___	___	Arthritis - Type: _____	___	___	Seasonal allergies
___	___	Back pain	___	___	Chronic cough
___	___	Extremity pain _____	___	___	Emphysema
___	___	Fibromyalgia	___	___	Shortness of breath
___	___	Gout	___	___	Black or bloody stool
___	___	Joint/muscle pain/stiffness	___	___	Constipation
___	___	Neck pain	___	___	Diarrhea
___	___	Osteoporosis	___	___	Acid reflux
___	___	Dizziness	___	___	Food sensitivities
___	___	Fainting	___	___	Nausea or vomiting
___	___	Memory issues	___	___	Blood in urine
___	___	Numbness/tingling _____	___	___	Incontinence
___	___	Seizures	___	___	Painful or frequent urination
___	___	Chronic ear infections	___	___	Diabetes
___	___	Dental problems	___	___	Thyroid problems
___	___	Ear or hearing problems	___	___	Anemia
___	___	Eye or vision problems	___	___	Easy bruising
___	___	Headaches or migraines	___	___	Eczema
___	___	Ringing in ears	___	___	Anxiety
___	___	Sinus trouble	___	___	Depression
___	___	TMJ problems	___	___	Alcoholism
___	___	Blood clots	___	___	Drug addiction
___	___	Chest pain or tightness	___	___	ADD/ADHD
___	___	Coronary artery disease	___	___	Psychiatric disorder: _____
___	___	High blood pressure	___	___	Irregular periods
___	___	Palpitations	___	___	Perimenopause
___	___	Erectile dysfunction	___	___	Menopause
___	___	Asthma	___	___	PMS
___	___	Environmental allergies			

Have you ever had:

Cancer __ No __ Yes Date: _____ Details: _____

Heart attack __ No __ Yes Date: _____ Details: _____

Stroke/TIA __ No __ Yes Date: _____ Details: _____

Please describe any other illnesses: _____

_____

Patient's Name: _____ Doctor's Initials _____ Page 3

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 (1 being very little and 10 being a lot) please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work: At home: At play:

Please circle what phrase best applies to each category:

Eating habits: excellent good fair poor Exercise habits: excellent good fair poor

Sleep: excellent good fair poor

How do you grade your physical health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting better ☐ Getting worse ☐

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____

Why are you here at this point in time?

_____

_____

_____

_____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

If patient is under 18 years of age:

I, _____, being the parent or legal guardian of _____ have read and fully
(Parent/Guardian name) (Child's name)
understand the **Chiropractic Informed Consent to Treat**, and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

Doctor's Initials _____ Page 4

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

Height:_____ Weight:_____ Blood Pressure:_____ /_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

(Print) Patient Name _____ **Date** _____

Patient or Legal Guardian's **Signature** _____

Authorization to discuss Personal Health Information (PHI)

I authorize Complete Health Chiropractic Center and/or Dr. Jennifer Pitcairn to discuss details of my care and personal health information with the following person/people:

_____ NONE

Name (print): _____ Relationship to me: _____

Name (print): _____ Relationship to me: _____

Please check one: This authorization is effective through:

___ Date: _____ OR ___ NO expiration unless revoked or terminated by the patient or the patient's personal representative.

****

Records:

I authorize Complete Health Chiropractic Center to share my records with my Primary Care Physician.

_____ Y _____ N

Primary Care Physician's name: _____

Clinic/Office _____

Address: _____ City _____ State _____ Zip _____

****

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____ Staff Name: _____

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Neck Pain Disability Index Questionnaire
Neck pain and headaches

Name: Date:

Please check the statement that most accurately matches how your neck discomfort is affecting you:

Section 1: Pain Intensity
__I have no pain at the moment.
__The pain is very mild at the moment.
__The pain is moderate at the moment.
__The pain is fairly severe at the moment.
__The pain is very severe at the moment.
__The pain is the worst imaginable at the moment.

Section 2: Personal Care
__I can look after myself normally without causing extra pain.
__I can look after myself normally but it causes extra pain.
__It is painful to look after myself and I am slow and careful.
__I need some help but manage most of my personal care.
__I need help every day in most aspects of self care.
__I do not get dressed, I was with difficulty and had to stay in bed.

Section 3: Lifting
__I can lift heavy weights without extra pain.
__I can lift heavy weights but it gives me extra pain.
__Pain prevents me from lifting heavy weights off the floor but I can manage if they are convenient places e.g. on a table
__Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
__I can only lift very light weights
__I cannot lift or carry anything.

Section 4: Reading
__I can read as much as I want with no pain in my neck.
__I can read as much as I want to with slight pain in my neck.
__I can read as much as I want with moderate pain.
__I can't read as much as I want because of moderate pain in my neck.
__I can hardly read at all because severe pain in my neck.
__I cannot read at all.

Section 5: Headaches
__I have no headaches at all
__I have slight headaches which come infrequently.
__I have slight headaches which come frequently.
__I have moderate headaches which come infrequently
__I have moderate headaches which come frequently
__I have headaches almost all the time.

Section 6 Concentration:
__I can concentrate fully when I want to with no difficulty
__I can concentrate fully when I want to with slight difficulty
__ I have a fair degree of difficulty in concentration when I want.
__ I have a lot of difficulty in concentrating when I want to.
__I have a great deal of difficulty in concentrating when I want to
__ I cannot concentrate at all.

Section 7: Work
__ I can do as much work as I want to.
__ I can only do my usual work, but no more.
__ I can do most of my usual work, but no more.
__ I cannot do my usual work.
__ I can hardly do any work at all.
__ I can't do any work at all.

Section 8: Driving
__ I drive my car without any neck pain.
__ I can drive my car as long as I want with slight pain in my neck.
__I can drive my car as long as I want with moderate pain in my neck.
__I can't drive my car as long as I want because of moderate pain in my neck.
__I can hardly drive my car at all because of severe pain in my neck.
__I can't drive my car at all.

Section 9: Sleeping
__I have no trouble sleeping
__My sleep is slightly disturbed (less than 1 hr. sleepless).
__My sleep is moderately disturbed (1-2 hrs. sleepless).
__My sleep is moderately disturbed (2-3 hrs. sleepless).
__My sleep is greatly disturbed (3-4 hrs. sleepless).
__My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10: Recreation
__I am able to engage in all my recreation activities with no neck pain at all.
__I am able to engage in all my recreation activities with some pain in my neck.
__I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
__I am able to engage in a few of my usual recreation activities because of pain in my neck.
__I can hardly do any recreation activities because of pain in my neck.
__I can't do any recreation activities at all.

Disability Questionnaire (Oswestry) - for low back

Name: Date:

Please check the statement that most accurately matches how your low back discomfort is affecting you:

Section 1: Pain Intensity
__The pain comes and goes and is very mild
__The pain is mild and does not vary much
__The pain comes and goes and is moderate.
__The pain is moderate and does not vary much.
__The pain comes and goes and is very severe.
__The pain is severe and does not vary much.

Section 2: Personal Care
__ I would not have to change my way of washing or dressing in order to avoid pain.
__I do not normally change my way of washing or dressing even though it causes some pain.
__Washing and dressing increases the pain, but I manage not to change my way of doing it.
__Washing and dressing increases the pain, and I find it necessary to change my ways of doing it.
__Because of the pain, I am unable to do some washing and dressing without help.
__Because of the pain, I am unable to do any washing and dressing without help.

Section 3: Lifting
__I can lift heavy weights without extra pain
__I can lift heavy weights but it gives me extra pain.
__Pain prevents me from lifting heavy weights off the floor, but I can manage if they are in convenient places.
__Pain prevents me from lifting heavy weights off the floor.
__Pain prevents me from lifting heavy weights, but I can manage medium weights conveniently positioned.
__I can only lift very light weights at the most.

Section 4: Walking
__I have no pain walking.
__I have some pain on walking, but it does not increase with distance.
__I cannot walk more than one mile without increasing pain.
__I cannot walk more than ½ mile without increasing pain.
__I cannot walk more than ¼ mile without increasing pain.
__I cannot walk at all without increasing pain.

Section 5: Sitting
__I can sit in any chair as long as I like.
__I can only sit in my favorite chair as long as I like.
__Pain prevents me sitting more than 1 hour.
__Pain prevents me sitting more than ½ hour.
__Pain prevents me sitting more than 10 minutes.
__I avoid sitting because it increases my pain right away.

Section 6 Standing:
__I can stand as long as I want without extra pain.
__I have some pain on standing, but it does not increase with time.
__ I cannot stand for longer than one hour without increasing pain.
__ I cannot stand for longer than ½ hour without increasing pain.
__I cannot stand for longer than 10 minutes without increasing pain.
__I avoid standing because it increases the pain right away.

Section 7: Sleeping
__I get no pain in bed.
__ I get pain in bed, but it does not prevent me from sleeping well.
__ Because of pain, my normal night's sleep is reduced by less than ¼.
__ Because of pain, my normal night's sleep is reduced by less than ½.
__ Because of pain, my normal night's sleep is reduced by less than ¾.
__Pain prevents me from sleeping at all.

Section 8: Social Life
__My social life is normal and gives me no extra pain.
__ My social life is normal, but increases the degree of pain.
__Pain has no significant effect on my social life apart from limiting my more energetic interests.
__Pain has restricted my social life and I do not go out as often.
__Pain has restricted my social life to my home.
__I hardly have any social life because of the pain.

Section 9: Traveling
__I get no pain while traveling.
__I get some pain while traveling, but none of my usual forms of travel makes it any worse.
__I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
__I get extra pain while traveling, which compels me to seek alternative forms of travel.
__Pain restricts all forms of travel.
__Pain prevents all forms of travel except that done by lying down.

Section 10: Changing degree of Pain
__My pain is rapidly getting better.
__My pain fluctuates, but is definitely getting better.
__My pain seems to bet getting better, but improvement is slow at present
__My pain is neither getting better nor worse.
__My pain is gradually worsening.
__My pain is rapidly worsening.

PIP (Personal Injury Protection) Agreement

What is Oregon Personal Injury Protection Insurance?
Personal injury protection insurance is medical and wage loss insurance that is required for every Oregon non-commercial auto policy.

Who does personal injury protection insurance cover?
It covers all of the occupants of the car. It also covers you if you are a pedestrian or a cyclist. If you do not have personal injury protection but are a pedestrian or cyclist hit by a car, the driver's personal injury protection covers you. You have the right to be treated by the medical providers of your choice. The insurance company cannot tell you who to see.

Why do I have to make a claim through my insurance company for personal injury protection benefits?
Oregon is a no-fault state. Oregon law provides that your insurance company provide personal injury protection insurance regardless of whose fault the accident is. This means Complete Health Chiropractic Center (CHCC) will bill the car insurance of the vehicle you were in. The insurance company of the car you were in is required either to pay:
1) For two years from the date of injury.
2) Up to the maximum of the PIP coverage on the policy for your medical care.
3) What they deem to be medically necessary.
It is important that you know what your PIP coverage amount is so that you are aware when/if you reach your maximum. This includes all providers you have seen. The minimum PIP coverage is $15,000 per person in the vehicle.

If you hit someone or something: Your insurance is the only insurance involved. CHCC will bill your car insurance for the period of time explained above.

If someone hit you and has insurance (3rd party insurance): If another person is at fault, their insurance is called the 3rd party. 3rd party insurance is required to pay for 2 years of medical care, or what they deem to be medically necessary. The 3rd party insurance does not pay for any of your medical care until you are released from care, and you have agreed to a settlement with them. In most cases the 3rd party insurance will reimburse all parties (such as your car insurance) once you have settled with them. You are not required to settle your medical claim with the 3rd party until you are released from care, and you do not have to sign a medical release of information authorization with the 3rd party insurance until you are ready to settle. If you have already signed a medical release, you can contact the adjuster and tell them you are revoking it. You do have to contact the 3rd party insurance before 2 years from the date of your accident to initiate a settlement.

If someone hit you and has no insurance (Uninsured motorist): CHCC will bill your car insurance. You will settle with your insurance for any pain and suffering under the uninsured portion of your insurance.

What if I am unable to work?
PIP will pay a portion of your lost wages if your injuries keep you from working. This applies whether you are an employee or self-employed. You must be off work for at least 14 days before you are entitled to PIP wage loss benefits, but your benefits will then be effective from day one. The insurance company will want your employer to verify your lost income.

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Attorney Information

Do you have an attorney on this case? ____Yes ___ No

If YES, attorney's name _____ **Phone number** _____
Address _____

If NO ____ **(please initial)** I agree to notify this office if I retain an attorney for my Personal Injury Protection case.

Insurance Information

Did the accident you were in occur in the state of Oregon? ___ Yes ____ No
If no, what state did the accident occur? _____

Is your insurance policy or the insurance policy of the vehicle you were issued in the state of Oregon?
__ Yes ___ No
If no, what state was the insurance issued in? _____

Patient's Insurance Company Information - (you)
Company Name:_____Policy # _____
Claim # _____ Adjuster's Name _____
Phone # _____ Extension _____
Do you have a *deductible* on your policy? **Y or N** **If yes,** how much? _____ Has it been met?_____
(If you do have a deductible on your policy, you must pay for the deductible within 60 days of the treatment start date.)

Insured's Insurance Information: - (If you were a passenger, or driving a vehicle other than your own)
Insured's name if other than you _____Phone _____
Company Name _____Policy # _____
Claim # _____ Phone # _____

OTHER Driver's Insurance Information – (Other car's driver)
Other Driver's Name (if another car was involved) _____Phone _____
Company Name _____Policy # _____
Claim # _____ Phone # _____

Certain services may not be covered by your personal injury protection insurance. You will be financially responsible for the services not covered. Some of these services may include: ice packs, supplements and other support products. I understand the above and agree that I am financially responsible for all services including any uncovered services.

Patient's/Guardian's Signature _____ **Date** _____

Print _____

For office use only

Date: _____

Verify claim# _____ Is the PIP claim open and benefits available? _____

Adjuster: _____ Phone # _____ Ext _____

Deductible/Amount? _____ Address to send claims: