



Northwest Chiropractic Clinic P.S

L & I Information Form

Patient Name: _____ Date: _____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Supervisor: _____

Accident Date: _____ Adjuster: _____

Have you filed a claim? Yes No; Claim #: _____

Did you report your injury to your employer? Yes No

Have you retained an Attorney? Yes No

(If you answered yes to this question, please fill out next section)

Attorney Information

Attorney's Name: _____

Attorney's Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____



Self-Insured Information

(This Section should be completed only if your place of employment carries its own L & I Insurance)

Name of Insurance Carrier: _____

Address: _____

City: _____ State _____ Zip: _____

Telephone: _____ Claim #: _____

Contact Person: _____