Personal Injury /Auto Accident or Slip & Fall Case

- Do you have No - Fault P. I. P. benefits? YES: ☐ NO: ☐
- Are there benefits left? YES: ☐ NO: ☐
- Do you have a deductible? YES: ☐ NO: ☐
- Deductible amount? $_______________ Has it been met yet? YES: ☐ NO: ☐
- If not, how much deductible is left to be met yet $_________________________________
- What percentage does your insurance cover _______________________________________ %
- What are the policy limits $____
- Do you have MED-PAY on your policy? YES: ☐ NO: ☐ (picks up the .20%)
- Do you have U/M (Uninsured Motorist Protection)? YES: ☐ NO: ☐
- Were you cited in the accident? YES: ☐ NO: ☐ Don't know: ☐
- Were you struck from: Behind: ☐ Front: ☐ R. Side: ☐ L. Side: ☐
- If other, please explain: ____
- Did you feel pain immediately? YES: ☐ NO: ☐ Where_____________________________
- If NO, when did you first start feeling pain? ____
- Since the injury are your symptoms: Getting worse: ☐ Improving: ☐
- Staying the same ☐ Changing ☐ (If changing, explain): ____
- Were You the: Driver ☐ Passenger ☐ Pedestrian ☐ Other ___________________
- Have you received massage therapy for this medical condition? Yes ☐ or No ☐
- Have you received massage therapy for any medical condition in the past? Yes ☐ No ☐ If YES, did it help? Yes ☐ No ☐
- If you live in a state that is not a no-fault state or do not have MED-PAY on your policy, you must supply the following information.

INFORMATION ON DRIVER OF VEHICLE AT FAULT:

Name: ____________________________________ Phone #: ______________________________

Address: ________________________________ Policy #: _________________________________

Have you obtained an attorney for this case YES: ☐ NO: ☐ IF YES, Please fill out our **Attorney Letter of Protection** and provide your attorney's name, phone and fax numbers.

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