Dowswell Chiropractic & Wellness Centre Dr. Lynn Dowswell, D.C. 241 West Street, Unit 3 Orillia, Ontario L3V 5C9

Telephone: 705.325.0832 Fax: 705.325.8401

MVA Insurance Claim Intake Form; Insurance Information

Client Name:		D.O.B.:		Age:		
		(Day/Month/Year)				
City:						
Home Phone:	V	Vork Phone:		Cell Phone	e:	
Primary Auto Insurance	Company:		Policy Number:			
Policy Holder?	Self	•		Other		
Policy Holder Name:		Policy Holder D.O.B:(Day/Month/Year)				
			·		(Day/Month/Year)	
Insurance Company Addre	ess:			-		
City:		Postal Code:	E	mail Address:		
Secondary Insurance Company:			Policy Number::			
Policy Holder?	Self	Spouse	C	Other		
Policy Holder Name:		F	Policy Hold	ler D.O.B:		
					(Day/Month/Year)	
Insurance Company Ad	dress:					
City:	P	ostal Code:	E	Email Address:		
		Claim Inform	nation			
Do you have Extended I	Health Care Be	enefits? Y	N If	yes, amount allo	owed annually:	
Amount of Remaining E	xtended Health	າ Care Benefits for th	ne current	t year:		
Claim Number:	Ao	ccident Date:	Ionth/Vea	Adjudicator N	lame:	
		(Day/iv	ionui/ i ea	u <i>j</i>		
Adjudicator Phone Num	ber:	Adjudicator Fax Number:				

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Describe the Accident & Injuries Sustained

 Client Name (Please Print)	Client Signature (Or Legal Guardian)	Date (Day/Month/Year)	