Lissa A. Grannis, D.C., DACS

Name ______________________________________

Sex M F DOB ___/___/___

Date and time of accident? ___ /___/ ___ _____________________

Where were you taken after the accident? _________________________________

Where did you feel pain? ____

Name of any other doctor(s) consulted since your accident?___________________

Treatment received? ____

____

How often did your receive care from the other doctor(s)?_____________________

Have you previously been injured in a similar manner? Yes No

Have you retained an attorney? Yes No If so, attorney's name and address?

____

Name of your insurance company____

Claim #:________________ Claim Manager________________________________

Address____
Street City State Zip

Responsible party name and address _______________________________________

____
Street City State Zip

Name of other persons insurance____

Address ____
Street City State Zip

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Lakewood, WA 98499-8108