Lockport Family Chiropractic

Health and Wellness Centre

AUTO ACCIDENT REPORT

Name: _____

Address: _____

Home phone: _____

MPI Claim #: _____ Adjuster: _____

Date of Accident: _____ Time: _____

Were there others in the vehicle with you?	Yes	No
Did you receive medical attention?	Yes	No
Did you need an ambulance?	Yes	No
Were X-rays taken?	Yes	No

If admitted to hospital, length of stay: _____

Description of Accident:

_____

_____

_____

_____

_____

_____

If for any reason, MPI will not accept or discontinues your claim, you are responsible for fees.

_____ _____

Signature Date