CORAZÓN
Chiropractic Clinic
Auto & Work Injury Care from the Heart

BP: ____

P:

WELCOME TO OUR CLINIC!

Today's date:	Date of injury and time:

MOTOR VEHICLE COLLISION (MVC) - PATIENT INFORMATION

Patient's full name (Last, First Middle):			
Marital status: ❑ Single ❑ Married ❑ Separated ❑ Widow			If a minor, name of parent/guardian(s):
Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #:
aStreet address:			Cell phone #: ( ) Text OK? ❑ Yes ❑ No
			Home phone #: ( )
Email:			Referred by:
Employer:			Employer phone #: ( )
Attorney:			Attorney Phone #: ( )
Primary Care Physician:			Phone #: ( )
Private Insurance:			Insurance ID #
Patient's relationship to insured: ❑ Self ❑ Spouse ❑Child ❑ Other (**If "Self," please skip to "INSURANCE INFORMATION"**)			Mailing address:
Insured's name:			
Birth date: / /	Best phone #: ( )		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	
Relationship to patient:	Best phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Corazon Chiropractic Clinic, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature: X	**Date:**

AUTO INSURANCE INFORMATION (PIP)

Adjuster's name:		Adjuster's address:
Phone #: ( )	Fax #: ( )	
Insurance company:		Email:
Claim #:		Is this an Oregon policy: ❑ Yes ❑ No If no, what state?
Policy #:		Patient was a: ❑ Driver ❑ Passenger ❑ Pedestrian
Was the driver of your vehicle considered "at fault:" ❑ Yes ❑ No		Witnesses:
PIP Maximum (leave blank if unknown):		

THE OTHER PARTY'S AUTO INSURANCE INFORMATION (LIABILITY)

Other driver's name:		Other driver's phone #:
Insurance company:		Claim #:
Is this an Oregon policy: ❑ Yes ❑ No If no, what state:		Policy #:
Adjuster's name:	Phone #: ( )	Fax #: ( )

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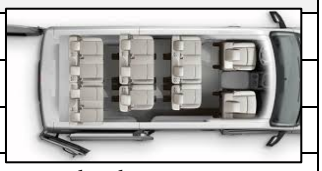
COLLISION INFORMATION



Where did you go immediately following the collision?

Exactly where were you **sitting** in the vehicle? (Driver, Left 3rd row passenger, etc) →

Did you lose consciousness? ❑ Yes ❑ No	For how long:
Was your headrest moveable? ❑ Yes ❑ No	Was it? ❑ under, ❑ directly behind, or ❑ above your head

Did the back of your seat break? ❑ Yes ❑ No

You used a: ❑ Seatbelt ❑ Lap belt only ❑ Car seat ❑ No seatbelt used ❑ other _____

Did your airbag deploy upon impact? ❑ Yes ❑ No	If yes, were you struck by the airbag? ❑ Yes ❑ No Where: _____

At the time of the impact, your **head** position was: : ❑ Left ❑ Right ❑ Forward

At the time of the impact, your **torso** position was: ❑ Left ❑ Right ❑ Forward

Were you **aware** of the impending collision? ❑ Yes ❑ No	If yes, did you **brace** for impact? ❑ Yes ❑ No

Which **hands** were on the steering wheel at the time of the accident? ❑ Both ❑ Right ❑ Left ❑ None

Was your foot on the brake pedal at the time of impact? ❑ Yes ❑ No	If yes, was it knocked off by the force of impact? ❑ Yes ❑ No
Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No	If so, what and where?

What items were you wearing during impact (hat, sunglasses, etc) that were knocked off by the force, if any?

Did you go to the hospital? ❑ Yes ❑ No	Were you transported via ambulance? ❑ Yes ❑ No

What type of tests were done at the hospital?

What was their diagnosis?

Did you receive any medication?

Please list all of the providers that you have seen related to this collision and the types of treatment you have received:

ACCIDENT INFORMATION

Exact location of accident:

Please describe the event in detail, in your words:	Please draw what happened in the accident:  Label "V1" as: Your vehicle/ your body Label "V2 - ∞": Other vehicles in order of impact

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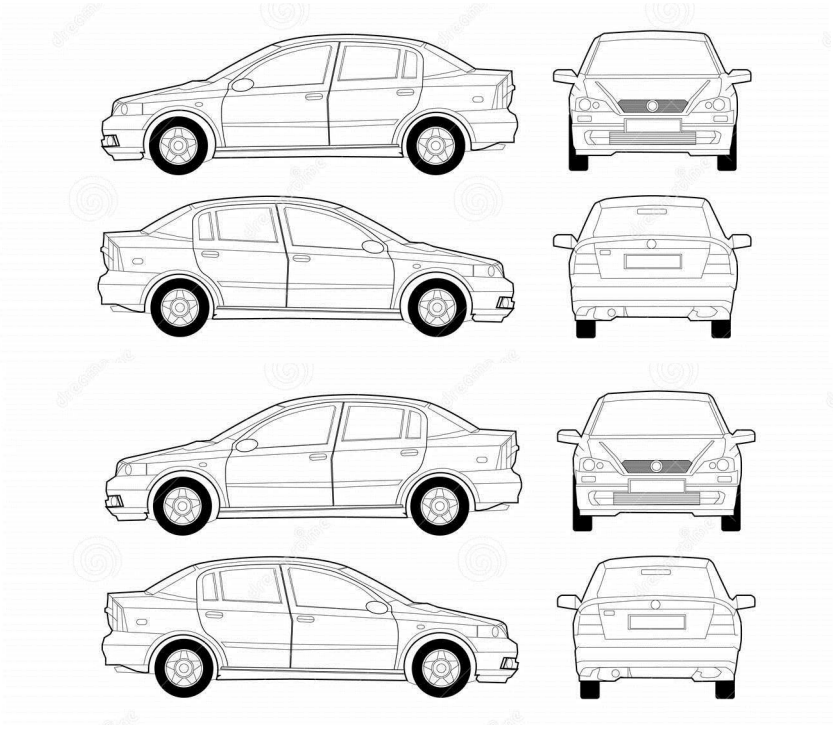
Year, Make & Model of your vehicle:
Year, Make & Model of other vehicle(s):
How fast was **your vehicle** going, at impact? Was the vehicle: ❑ Accelerating or ❑Decelerating?
Road conditions were (dry/wet/icy, etc):
Visibility was (clear/foggy/limited by XYZ obstacles, etc):
Did your vehicle move from the force of impact? ❑ Yes ❑ No If yes, how far?
Did the police respond to the scene? ❑ Yes ❑ No
Did they do a report? ❑ Yes ❑ No
Did anyone receive a citation? ❑ Yes ❑ No Who?
Estimated damage to **your** vehicle? $_____
Please describe the damage to **your** vehicle:



Damages to **your** vehicle

Damages to the **other** vehicle

Symptoms Since the Incident

How soon did you start feeling symptoms?	What did you feel?

Please check all of the symptoms you have felt since the incident: ❑ Pain ❑ Headache ❑ Numbness ❑ Tingling ❑ Weakness ❑ Fatigue

❑ Faint ❑ Fever ❑ Dizziness ❑ Confusion ❑ Chest pain ❑ Nausea ❑ Vomiting ❑ Swelling ❑ Discoloration or Bruising ❑ Cuts

❑ Bowel or bladder changes ❑ Sleep disruption ❑ Changes to vision ❑ Changes to hearing ❑ Other - Describe:

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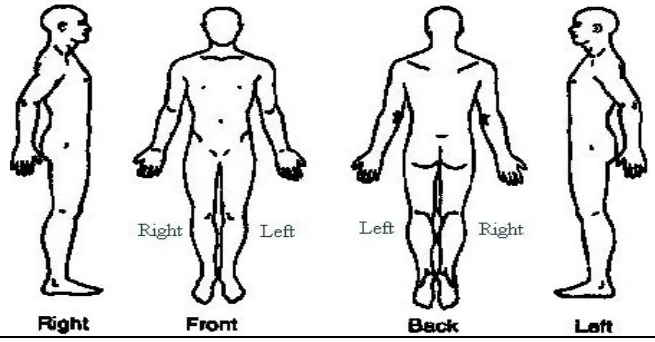
Please use the diagram to mark your current symptoms:

Legend = Pain (circle) Ache (a) Spasm (S) Numbness (N)
Burning (B) Tingling (t) Swelling (edema) (e)



Did you have any symptoms in injured areas <u>immediately PRIOR</u> to this incident? ❑ Yes ❑ No If yes, what:

First complaint area:	Describe the symptoms:
What makes it feel worse?	What makes it feel better?
What percentage of your waking hours do you feel symptoms (0-100%)?	Is it getting: ❑ Better ❑ Staying the same ❑ Getting worse
What is the intensity of your symptoms? (Circle one of the following)	0 1 2 3 4 5 6 7 8 9 10
Second complaint area:	Describe the symptoms:
What makes it feel worse?	What makes it feel better?
What percentage of your waking hours do you feel symptoms (0-100%) ?	Is it getting: ❑ Better ❑ Staying the same ❑ Getting worse
What is the intensity of your symptoms? (Circle one of the following)	0 1 2 3 4 5 6 7 8 9 10
Third complaint area:	Describe the symptoms:
What makes it feel worse?	What makes it feel better?
What percentage of your waking hours do you feel symptoms (0-100%) ?	Is it getting: ❑ Better ❑ Staying the same ❑ Getting worse
What is the intensity of your symptoms? (Circle one of the following)	0 1 2 3 4 5 6 7 8 9 10
Fourth complaint area:	Describe the symptoms:
What makes it feel worse?	What makes it feel better?
What percentage of your waking hours do you feel symptoms (0-100%) ?	Is it getting: ❑ Better ❑ Staying the same ❑ Getting worse
What is the intensity of your symptoms? (Circle one of the following)	0 1 2 3 4 5 6 7 8 9 10
Fifth complaint area:	Describe the symptoms:
What makes it feel worse?	What makes it feel better?
What percentage of your waking hours do you feel symptoms (0-100%) ?	Is it getting: ❑ Better ❑ Staying the same ❑ Getting worse
What is the intensity of your symptoms? (Circle one of the following)	0 1 2 3 4 5 6 7 8 9 10

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Past Health History

Please list any serious and/or chronic illnesses you have or have had:

Please list any prior hospitalizations or surgeries, with dates for each:

Please list any medications you currently take or took for an extended period:

Please list any prior work-related injuries with dates and duration of any treatment received:

Please list any prior motor vehicle injury or other physical trauma with dates and duration of any treatment received:

Please state your total number of pregnancies:

Please list any allergies you have:

Have you seen a chiropractor before? ❑ Yes ❑ No

If yes, whom, when and why?

When was your last physical?	Please list any findings or remarks:

Personal History

Please check all conditions if you have been diagnosed with them and approximately when it was diagnosed, in the space nearby:

❑ Anemia ❑ Asthma ❑ Cancer ❑ Diabetes ❑ Epilepsy ❑ Glaucoma ❑ Heart disease ❑ High blood pressure ❑ Kidney disease

❑ Psychological disorders ❑ Tuberculosis

Please briefly describe your work duties:

How would you describe your home life?

How many children do you have and what ages are they?

Are you on any special diets? ❑ Yes ❑ No

How would you describe your diet?

Do you exercise regularly? ❑ Yes ❑ No	Has this injury affected your routine? ❑ Yes ❑ No If yes, how so?
Do you have regular hobbies? ❑ Yes ❑ No	Has this injury affected your hobbies? ❑ Yes ❑ No If yes, how so?
Do you drink alcohol? ❑ Yes ❑ No	How much and how often?
Do you use tobacco products? ❑ Yes ❑ No	How much, how often and for how long?

Family Health History

Please check all conditions found in your family, state who has it (their relation to you), and approximately when it was diagnosed, in the space nearby:

❑ Anemia ❑ Asthma ❑ Cancer ❑ Diabetes ❑ Epilepsy ❑ Glaucoma ❑ Heart disease ❑ High blood pressure ❑ Kidney disease

❑ Psychological disorders ❑ Tuberculosis

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Assignment of Benefits and Clinic Policy Acknowledgement

1. I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my rights and interests to Corazón Chiropractic Clinic, LLC, hereafter referred to as the "medical provider," to pursue and obtain payment from the above mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of Oregon.
2. I, the patient, irrevocably assign to the medical provider all my rights and benefits under the insurance contract for payment for services rendered to me.
3. I, the patient, do hereby authorize my bodily injury attorney and/or insurance carrier to pay directly to the medical provider any monies due on my account, or the same to be deducted from any settlement made on my behalf.
4. There is no grace period. Default of the Payment Terms and Conditions of this Agreement the undersigned agrees to pay a 30% collection fee against the outstanding balance at the time of assignment to agency and all reasonable attorney fees and other legal costs incurred in the collection of this account. Venue of any action shall be Washington County.
5. If I, the patient miss more that one week of care without notifying the clinic of a reason - family emergency, vacation, etc - the clinic will be forced to close my case.
6. If I, the patient, fail to inform the clinic that I will miss my visit, three or more times during care, the clinic will be forced to close my case. If I, the patient, miss my scheduled visit, I will call the clinic by the end of the day to reschedule and to avoid penalty. I understand that there is a **$ 50** penalty for missing a visit scheduled for massage, and not informing the clinic within 24 hours of the scheduled time.
7. I, the patient, do hereby acknowledge that I will not file suit or pursue arbitration for the payment of the above provider's medical bills. I understand that the above medical provider has a collection agency and will collect payment on my behalf from the insurance carrier.
8. In the event that the insurance carrier or the vendor designated by the insurance carrier does not accept my assignment or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit or pursue arbitration directly against the carrier in my name or allow the medical provider to amend the lawsuit or arbitration to include my name.
9. Further, in response to any reasonable request for cooperation, I agree to cooperate with the medical provider and their collection agency in any attempts by such doctor and attorney to pursue such claims, or to choose inaction, against the patient's Personal Injury Protection insurance carrier in the patient's name.

Patient Signature: _____ Date: _____

Name: _____
(Please print name of **patient**)

Signature of **Guardian** (when applicable): _____ Date: _____

Name: _____
(Please print name of **guardian**)

In the instance a translator was needed, please fill out below:

Signature of **Translator**: _____ Date: _____

Name:_____
(Please print name of **Translator**)

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Oswestry Low Back Pain Questionnaire

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Score (Staff to complete):**_____

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than ten minute without increasing pain.
- ☐ I avoid standing, because it increases the pain straight away.

Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than one than one quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights, at the most.

Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, my e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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Neck Disability Questionnaire

Patient Name: _____ **Date:** _____
Patient Signature: _____ **Score (Staff to complete):** _____

Pain Intensity
- ❑ I have no neck pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Concentration
- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Personal Care
- ❑ I can look after myself normally without causing extra neck pain.
- ❑ I can look after myself normally, but it causes extra neck pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal careful.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

Work
- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Lifting
- ❑ I can lift heavy weights without causing extra neck pain.
- ❑ I can lift heavy weights, but it gives me extra neck pain.
- ❑ Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e. on a table
- ❑ Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Driving
- ❑ I can drive my car without neck pain.
- ❑ I can drive my car with only slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because moderate neck pain.
- ❑ I can hardly drive at all because of serve neck pain.
- ❑ I can't drive my car at all because of neck pain.

Reading
- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Sleeping
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly distributed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

Headaches
- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headache that come frequently.
- ❑ I have serve headaches that comes frequently.
- ❑ I have headaches almost all the time.

Recreation
- ❑ I am able to engage in all my recreational activities with no neck pain.
- ❑ I am able to engage in all my recreational activities with some neck pain
- ❑ I am able to engage in most, but not all activities with some neck pain.
- ❑ I am able to engage in a few of my recreational activities because of neck pain.
- ❑ I can hardly do recreational activities due ti beck pain.
- ❑ I can't do any recreational activities due to neck pain.

Corazón Chiropractic Clinic
2251 SE Tualatin Valley Highway
Hillsboro, OR 97123

Minimal/Moderate/Severe/Crippled/80-100%

Phone: (503) 648-HELP(4357)
Fax: (503) 648-4358
www.corazonclinic.com

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Informed Consent to Chiropractic Treatment

Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom.

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation or mobilization, are required to inform patients that there are or may be some risks associated with such treatment. In particular:

a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.

b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 2-5 million treatments.

c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.
Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (upper limbs and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Patient Signature: _____ Date: _____

Name: _____
(Please print name of **patient**)

Signature of **Guardian** (when applicable): _____ Date: _____

Name: _____
(Please print name of **guardian**)

In the instance a translator was needed, please fill out below:

Signature of **Translator**: _____ Date: _____

Name:_____
(Please print name of **Translator**)

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Medical Records Request Form

Patient Name: _____

Date of Birth: _____ Today's Date: _____

I hereby authorize: _____

_____

_____

To release copies of:

☐ All Medical Records, to include chart notes, examinations, imaging and reports

☐ Medical Records to include everything EXCEPT imaging materials

☐ Other _____

Release medical records by mail or fax (preferred) to:

Corazon Chiropractic Clinic, LLC
2251 SE Tualatin Valley Highway
Hillsboro, OR 97123
Ph: 503-648-4357
Fax: 503-648-4358

Purpose or need for information: To continue medical care/ treatment.

I place no limitation on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders, or HIV infection.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Please contact this clinic with any questions or comments.

Signature: _____ Date: _____

Witness: _____ Relationship: _____

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Rivermead Post Concussion Symptoms Questionnaire

Modified (Rpq-3 And Rpq-13)[42] Printed With Permission: Modified Scoring System From Eyres 2005 [28]

Name: Date:

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

0 = not experienced at all
1 = no more of a problem
2 = a mild problem
3 = a moderate problem
4 = a severe problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	Not Experienced	No more of a Problem	Mild Problem	Moderate Problem	Serve Problem
Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking Longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity (easily upset by bright light)	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4
Are you experience any other difficulties? Please specify, and rate as above.					
1.	0	1	2	3	4
2.	0	1	2	3	4

Administration only:	
RPQ-3 (total for first three items)	
RPQ-13 (total for next 13 items)	

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Name: _____ **DOB:** _____

If applicable: Attorney:_____ **Ph:**_____ **Fx:**_____

Claim#:_____ **DOL:**_____