PERFORMANCE
INJURY CARE & SPORTS MEDICINE

INJURY INFORMATION SHEET

Patient Name: _____ **Birthdate:** _____ **Date:** _____

Part of Body Injured: _____ ☐ **Right** ☐ **Left**

PCP: _____ **Referred By:** _____

Information must be completed in order for us to bill for services. If not completed, patient will be responsible for full payment at time of service

WORKER'S COMPENSATION

EMPLOYER AT TIME OF INJURY: _____ **Phone #:** _____

Please explain how accident/injury occurred?

_____

_____

DATE OF INJURY: _____ **LAST WORKED DATE:** _____

WORK COMP INSURANCE CARRIER: _____

WORK COMP CARRIER ADDRESS: _____
STREET ADDRESS **CITY** **STATE** **ZIP**

CLAIMS EXAMINER: _____ **PHONE #:** _____

CLAIM #: _____ **FAX #: (if available)**_____

AUTO ACCIDENT

POLICY HOLDER: _____

CLAIM #: _____**ACCIDENT DATE:**_____

INSURANCE AGENCY: _____**PHONE #** _____

AGENT: _____ **FAX # (if available)**_____

ADDRESS: _____
STREET ADDRESS **CITY** **STATE** **ZIP**

PAIN / INJURY INFORMATION

Date of Injury (if applicable): _____

PLEASE EXPLAIN HOW PAIN / INJURY BEGAN:

_____

_____

IMPORTANT INFORMATION (PLEASE READ and SIGN)

** I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.*

** I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.*

** I understand that I am financially responsible for all charges whether or not paid by my insurance. If no insurance payment after 90 days the balance becomes my responsibility.*

** I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 50% of the balance, including attorney/court costs will be added to the balance of my account.*

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____