

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: _____