

NAME: _____ TODAY'S DATE: _____

BODY PART: _____ INJURY DATE: _____

REFERRED BY: _____

LOCATION:

- _____ HOME
- _____ WORK
- _____ FARM
- _____ RECREATION AREA
- _____ PLAYGROUND
- _____ OTHER

TYPE OF ACCIDENT:

- _____ ON THE JOB
- _____ AUTO ACCIDENT
- _____ BICYCLE
- _____ INVOLVING AN ANIMAL
- _____ DOG BITE
- _____ SPORTS (WHICH SPORT)
- _____ FALL - STAIRS/STEPS
- _____ FALL - HOLE
- _____ FALL - LADDER
- _____ FALL - BED/CHAIR
- _____ FALL - LEVEL GROUND
- _____ GUNSHOT WOUND
- _____ FIGHT

PLEASE DESCRIBE WHAT HAPPENED: _____

DUE TO THE INCREASED INFORMATION REQUIRED BY INSURANCE COMPANIES, WE ARE ATTEMPTING TO PROVIDE THEM WITH A MORE COMPLETE CLAIM. HOPEFULLY THIS WILL ALLEVIATE SOME OF THE DELAY IN PROCESSING AND REDUCE THE QUESTIONNAIRES SENT TO YOU, THE PATIENT.

WE BILL INSURANCE AS A COURTESY TO OUR PATIENTS. AS THE PATIENT, YOU ARE RESPONSIBLE FOR PAYMENT OF MEDICAL SERVICES PROVIDED. UNLESS THIS IS AN ON-THE-JOB INJURY, WE ASK THAT PAYMENT BE MADE WITHIN 60 DAYS OF THE SERVICE. IF AN ON-THE-JOB CLAIM IS DENIED, RESPONSIBILITY RESTS WITH THE PATIENT FOR PAYMENT.