ACCIDENT FORM

It is the responsibility of the patient to inform our office of any and all insurance information so that we may file your claim correctly. You will be responsible for any unpaid claims due to incomplete or incorrect information submitted to this office.

Is the reason for your visit due to an injury or accident? ___YES ___NO

Date of injury or accident: _____

What type of accident did you have? ___Auto ___ Work ___School ___Home

Other: _____

Was a third party responsible for your accident ____ YES ____ NO

Name, Address and Phone number of individual or Company:

_____

_____

Claim Number: _____ Name of Adjuster: _____

Date you stopped working: _____ Work number: _____

Employer or Supervisor: _____

Description of accident:

_____

_____

_____

_____

Date your company or supervisor was notified: _____

Signature: _____ Date: _____