ACCIDENT INFORMATION FORM

COMPLETION OF THIS FORM IS REQUIRED IF WE ARE FILING AN INSURANCE CLAIM FOR YOU.

Patient's Name:_____Date of Birth:_____

Have you filed or do you plan to file a Worker's Compensation claim for this accident/injury? ☐**Yes** ☐**No**

Have you filed or do you plan to file an Automobile claim for this accident/injury? ☐**Yes** ☐**No**

Is a third party responsible for your accident/injury? ☐Yes* ☐No
*(This would be a person or company **other than** yourself or your medical insurance company.)*
*IF YES:
Name of person or Company:_____
Insurance Company:_____
Claim #:_____Phone #:_____

Are you represented by and attorney for this accident/injury? ☐Yes* ☐No **
*If yes: Name of Attorney:_____
**If no: Are you planning to seek legal representation in the future? ☐Yes ☐No

Accident/Injury Details

Date of Accident/Injury: _____/_____/_____ **Body Part Injured**:_____

Where did the accident/Injury occur? *(Home, Auto, Work, Etc.) (include City and State)*

_____

_____

How did the Accident/Injury happen?

_____

_____

Please note: If you have Health Insurance we will file it for you. However, the entire balance will be your responsibility in the event claims are denied by them. We will file your auto insurance or liability insurance for you as a courtesy. However, if we have not had any response from them within 45 days, the balance will be made your responsibility.
Medicare Patients: We are required by law to file with your liability insurance prior to billing Medicare. Please make sure you provide us with all the correct information. Thank you!
This form may be mailed or faxed to your insurance company.

_____ _____
(Signature of patient or guardian if minor) Date