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

NEW INJURY PATIENT VISIT INFORMATION

Patient's Name:_____Date of Birth:_____

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 #:_____

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

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: _____/_____/_____
Where did the accident/Injury occur? (include city and state)

_____
_____
How did the Accident/Injury happen?

_____
_____

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 your responsibility.

Signature:_____Date signed:_____
(Signature of patient or guardian if minor)