

Date:  
 Patient:  
 Cert. No:  
 Date of Service:  
 Provider:

If you check **Yes** in any of the boxes below, complete the applicable column in Section A plus Section B. If you check **No** in all three boxes, complete Section B.

**Section A**

<b>Work Related</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Complete questions below if Yes)	<b>Auto Related</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Complete questions below if Yes.)	<b>Other Injuries</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (Complete questions below if Yes.)
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<p>Was condition reported to Patient's employer? <input type="checkbox"/> yes <input type="checkbox"/> no            Has patient filed an accidental injury claim with employer or the Worker's Comp. Insurance carrier? <input type="checkbox"/> yes <input type="checkbox"/> no            If yes, has the claim been: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Other(explain) _____</p> <p>If denied, did the patient appeal the denial through the Labor Dept? <input type="checkbox"/> yes <input type="checkbox"/> no            If yes, what is/ was the date of the hearing?            _____</p> <p>Name/ Address of patient's employer:            _____            _____</p> <p>Phone # _____            Name/Address of Worker's Comp. Insurance Carrier:            _____            _____</p> <p>Are you <b>exempt</b> from Worker's Comp? under State/Federal Law?  <input type="checkbox"/> Yes <input type="checkbox"/> no            If yes: <input type="checkbox"/> self- employed <input type="checkbox"/> Other Explain:            _____</p>	<p>Was the patient a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (explain) _____</p> <p>Number of Vehicle involved _____            Street, City &amp; State where the Accident occurred:            _____            _____</p> <p><u>If passenger, driver's name &amp; address:</u>            _____            _____</p> <p>Driver's Insurance Company name and Address:            _____            _____</p> <p>Do you intend to make a claim against the responsible person?  <input type="checkbox"/> Yes <input type="checkbox"/> no            Name/ address of person responsible for accident: _____            _____</p> <p>Insurance company of the responsible Person: _____            _____</p>	<p>Was the patient's condition The result of:  <input type="checkbox"/> A defective product  <input type="checkbox"/> An animal bite  <input type="checkbox"/> A slip and fall  <input type="checkbox"/> Occurred on someone else's property  <input type="checkbox"/> Other (explain) _____            (Use reverse if necessary)</p> <hr/> <p>Was another party responsible for this accident? <input type="checkbox"/> Yes <input type="checkbox"/> no</p> <p>Do you intend to file a claim against the responsible party? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name/address of person responsible for accident: _____            _____</p> <p>Insurance company of the Responsible Party _____            _____</p> <hr/> <p>Policy Claim# _____</p>
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**Section B**

Date of Accident or injury \_\_\_\_\_

Description of the accident/injury (Use reverse if necessary) \_\_\_\_\_

If you have hired an attorney, please indicate name and address: \_\_\_\_\_  
 \_\_\_\_\_ Phone # \_\_\_\_\_

Please indicate a phone number at which you can be reached in case of further questions. Tel. \_\_\_\_\_

I certify the above information is true to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: FAILURE TO RESPOND COULD DELAY OF PROCESSING YOUR CLAIMS!!**