

INSURANCE INFORMATION

Name and address of **PRIMARY** Insurance Company *(see below) Effective Date

Name of Insured Person Date of Birth Relation to Patient ID# or Social Security # Group #

NOTE: Secondary Insurances - the following information is required by Primary Insurance Carriers

Name and address of **SECONDARY** Carrier *(see below) Effective Date

Name of Insured Person Date of Birth Relation to Patient ID# or Social Security # Group #

*Please initial that you understand, we do / do not participate with your insurance or accept their fee schedule amount _____ .
(circle one) (Initials)

ACCIDENT INFORMATION

Date of Injury Place of Injury (at home, work, etc.) Is a lawsuit pending? Yes/No
(circle one)

If Yes, name and address of your attorney Phone#

Describe how accident happened:

WORK INJURY

(Complete this section **only** if you are being seen today for a work-related injury)

Did you report it to your employer? Yes/No When? _____ To Whom? _____
(Date) (Name and Title)

Name and Address of Employer **at time of accident** Phone #

Name and Address of Industrial Insurance Carrier (**not** group insurance company) Phone #

Name of Case Worker File or WCAB Case # Services authorized by (name)

EMERGENCY SERVICE

Name of Hospital Was surgery performed? Yes/No
(circle one)

Emergency Room / Outpatient / Inpatient Date Admitted _____ Date Discharged _____
(circle one)

DATE OF ADMISSION	STATUS <input type="checkbox"/> 23 hr. hold <input type="checkbox"/> Outpatient	IS YOUR CONDITION CAUSED BY AN ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE/TIME OF ACCIDENT	DO YOU HAVE AN ADVANCED DIRECTIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No
FAMILY PHYSICIAN		REFERRING PHYSICIAN		SURGEON
ALLERGIES			DIAGNOSIS	