Patient's HPP Guarantor #: ______________________ Patient's HPP Acct#: ______________

Charleston Bone and Joint

Patient Information – Injury and/or Pain Form

This information is required by most insurance carriers when medical services are related to any Accident/Injury/Incident.

To Be Filled Out by Patient: Injury/Accident/Incident Information

Patient's Name: ______________________________ **Date of Birth:** ______________

Date of Accident, Incident OR Approx. First Date of Symptom(s): ______________________

Where Accident Occurred: (Please check one)

- ☐ **Work Related (Give Employment Information Below)**
- ☐ **Auto Accident** **State:** __________ **Note: If auto accident, the State in which the accident occurred is required**
- ☐ **Home**
- ☐ **Other, Please Specify:** ____

Brief description of how accident/incident or onset of symptoms occurred.
Example: Twisted ankle/foot after stepping in hole in yard at home yesterday at approx. 5pm

____
____
____

If not work related, please skip to signature section.

Employment Information for Work Related Injury

This information is required for all work related injuries when a Worker's Compensation Insurance Carrier should be billed. Please give the staff any paperwork you received from your employment and/or their worker's compensation insurance, so we may file your services properly. Without the correct billing information, for a work related injury, you may be held responsible for payment.

Name of Employer: ____

Name of Employer Contact: ______________________ **Contact Phone: (_____)_____-__________**

Work Comp Policy/Claim #: ______________________

Name and address of Work Comp Carrier:

____
____
____
____

If Dept of Labor*, Diagnosis Code(s): __________

*Provide letter from DOL. The DOL should have sent you a letter approving your claim and assigned a diagnosis.

Name of Adjuster: ______________________________ **Phone # (_____)________-__________**

Name of person providing information: ______________________ **Relationship to Patient:** __________

To the best of my knowledge, the information provided above is correct.

Patient's Signature: ______________________________ **Date:** ______________________

Created 3/24/2011
S://physicianb&c/audits/forms/Accident Information Sheet