INSIGHT
ORTHOPEDIC SPECIALISTS

Worker's Compensation Accident Form

This information is needed to makes sure that your bills are sent to the proper insurance. It is your responsibility to provide our office with correct information. If your information is incorrect or out-of-date, you may receive a bill. If you have any questions, please contact our Billing Office.

Initials ____ ____ ____ ____ ____ ____

Patient Name _____ **Today's Date** _____/_____/_____

Insurance Company:_____ **Claim Number:** _____

Insurance Adjuster:_____ **Phone Number of Adjuster:** _____

Address to send Claims: _____

Attorney Information:

If you have an Attorney Involved, do we have permission to contact your attorney and/or share information regarding your medical care, including but not limited to progress notes and billing information pertaining to our facilities? ❑ Yes ❑ No _____

Law Firm Name: _____ **Attorney Name:** _____

Phone Number: _____ **Fax:** _____

Address: _____

Is your Medical Insurance Primary? ❑ Yes ❑ No **Is your claim in litigation?** ❑ Yes ❑ No

Date of Accident _____/_____/_____ **Any additional accidents?** _____

Accident Details

Accident Description _____

_____

_____

_____

_____

Initials

What were your injuries? _____

_____

_____

_____

_____

Hospitalized

Were you hospitalized? ❑ Yes ❑ No. If yes, please answer the questions below.

What hospital did you go to? _____

When were you hospitalized? ❑ Immediately ❑ Later the Same Day ❑ Next Day ❑ Date _____

How were you transported to the hospital? ❑ Ambulance ❑ Life Flight ❑ Private Transportation

What did the hospital recommend? ❑ No Instructions ❑ See this Clinic

❑ See Own Doctor ❑ See Orthopedic Specialist ❑ See Neurologist ❑ See Neurosurgeon ❑ Prescription Medication

❑ Other: _____

Did you have any imaging taken? ❑ Yes ❑ No **If yes, what areas?** _____

Did you have imaging taken prior to your accident? ❑ Yes ❑ No

Have you seen a doctor before the accident for similar symptoms? If yes, please explain the symptoms and what doctor.

_____

_____

Patient Signature:_____ Date:_____