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Patient Injury Questionnaire

Patient Name: ____ **DOB**: ______________

Is your injury related to a work or motor vehicle accident? (Please Circle) **Yes** **No**

If you circled **Yes** above, please answer the following questions in **Section One**.
If you circled **No** above, please continue to **Section Two.**

Section One:

What date did the injury occur? ____

Where did the injury occur? ____ State:__________

How did the injury occur? ____

Is your injury at the fault of someone else? (Please Circle) **Yes** **No**

Is your injury due to a car accident or fall? (Please Circle) **Yes** **No**

Is your injury work related? (Please Circle) **Yes** **No**

Did you report the incident to your employer? (Please Circle) **Yes** **No**

If **yes**, please provide the name you reported the injury to: ____

Who is your employer? ____

Do you expect to receive Worker's Compensation benefits? (Please Circle) **Yes** **No**

Section Two / Additional Insurance Information:

Do you have an additional insurance plan that may cover medical claims? (Please Circle) **Yes** **No**

Insurance plan name: ____

Insurance policy number: ____

Relationship to the insured: (Please Circle) **Self** **Spouse** **Child** **Parent** **Other**

Effective Date: ____

Is the insurance plan currently active? (Please Circle) **Yes** **No**

Signature: ____ **Date**: _________________