LAWRENCE OTOLARYNGOLOGY ASSOCIATES, P.A.
ACCIDENT/ INJURY FORM

Office use only

_____ DOCTOR TO SEE PATIENT FOR EVALUATION ONLY. Todays Date: _____

_____ DOCTOR TO SEE PATIENT FOR EVALUATION AND TREATMENT.

_____ DOCTOR TO SEE PATIENT FOR TREATMENT ONLY.

PLEASE COMPLETE INFORMATION BELOW

** Injury Due to: (please circle) School Sports: Yes / No Recreational Sport: Yes / No Altercation: Yes / No
Injury due to something other than listed above: _____

Please fill out Other Party information completely especially if a Third Party Insurance will be involved.

Patient Name: _____ DOB:_____ Doctor: _____

Current Address: _____

Current Home Phone: _____ Current Work Phone: _____

** Date of Injury: _____ Time of Injury: _____

Address Where Injury Happened: _____

How Did the Injury Happen: _____

What was Injured: _____

Chief Complaint: _____

Was a Police Report Filed Yes / No Do you plan on filing charges Yes / No

Police Case Number: _____

Did you go to the ER?: Yes / No Are there Films: Yes / No Are there Medical Records: Yes / No

Does the patient have personal health insurance: Yes / No Please Present Card to Receptionist

Insurance Company Name: _____ Phone Number: _____

Policy Number: _____ Claim Number: _____

Mail Bills To (If other than yourself): _____

_____

If you are here due to a WORK-COMP injury please fill out Employer and Other Party information completely.

Patients Employer At Time of Injury_____

Phone:_____

Employer's Address: _____

Contact Name: _____ Work comp claim # _____

Other Party Information: (Home Owners Ins., Third Party Auto Ins., Business Ins., Work CompIns., ETC)

Name: _____ Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Company Name: _____ Phone: _____

Agent's Name: _____ Case Number: _____

Address: _____ City: _____ St: _____ Zip: _____

Claim Adjuster: _____ Adj. Phone Number: _____

I UNDERSTAND THAT IF THE INSURANCE COMPANY HAS NOT PAID WITHIN 90 DAYS, IT IS MY RESPONSIBILITY TO MAKE PAYMENT ARRANGEMENTS.

PATIENT/GUARDIAN SIGNATURE _____ DATE: _____
Required **Required**

To be completed by office personnel only: Checked by _____ and _____ Copy of Ins on file: Yes / No