

Accident Detail

Many Insurance Companies write requesting accident detail after we send in a claim. Please indicate if today's services are the result of an accident/injury/occurrence. Please answer the following questions and explain how this accident or injury occurred. If this is not related to an accident/injury/occurrence, please state "not applicable" and sign at the bottom of this form. To process your claims, we need to complete details.

Patient Name *
 First Name * Middle Name Last Name *

 Prior Last Name Preferred Name

Is your current visit the result of an accident? * Yes (please complete below) No (sign the bottom)

If yes, please complete the following section:

Date of Accident:
Date

Place of Accident:

Describe how the injury occurred:

Were you treated for this condition previously? Yes No

Were you hospitalized? Yes (please complete next question) No (skip next question)

If Yes, please give hospitals and dates:

Other doctors that have treated you for this condition:

To the best of my knowledge the above statement are true. Unanswered questions indicate they do not apply. Many Insurance Companies write requesting accident detail after we send in a claim. Please indicate if today's services are the result of an accident/injury/occurrence. Please answer the following questions and explain how this accident or injury occurred. If this is not related to an accident/injury/occurrence, please state "not applicable" and sign at the bottom of this form. To process your claims, we need to complete details. My signature authorizes my Insurance to receive any and all information concerning claims filed on my behalf by Advanced Orthopedic Center.

Signature * Type your name in lieu of a signature.

Date: