Patient Name: _____ **Date of Birth:** _____

INJURY/ ACCIDENT/ OR WORKMEN'S COMPENSATION INFORMATION SHEET

☐ **Visit is a result of an auto accident**
☐ **Visit is in result of a workmen's compensation injury**
☐ **Visit is a result of an accident that involves/ may involve a liability**
☐ **Accident, but no liability involved**

Accident History

Injury or Accident Date:_____ Has an attorney been consulted? ☐ YES ☐ NO

Injury Detail: (How? When? Where?) _____

_____

_____

Are you currently off work for this problem? ☐ YES ☐ NO

If yes, last date worked:_____

Current Medications: *Even if you are not currently taking any medications please provide the name of your preferred pharmacy so that we may better serve you.*

Pharmacy: _____ **Phone**: _____

Pharmacy location:_____

List of ALL Medications You are Currently Taking

Name Of Medication:	Strength:	Dosage:

The above statements are true to the best of my knowledge. I understand I am financially responsible for all charges not covered and/or denied by workmen's comp, auto or liability insurance. Only if workers compensation denies your claim will we bill your health insurance.

Patient's Signature: _____ Date: _____