Accident/ Injury Questionnaire

Patient Name_____ Birthdate _____
Patient Address _____
City _____ State _____ Zip _____
Telephone (_____)_____ Social Security # _____

1. **Is today's visit related to an accident/ injury?** **YES NO**
   Date of accident _____/_____/_____ Time of accident _____
   Location of accident _____
   Please describe the accident/ injury _____
   _____
   _____

2. **Was the accident/ injury due to a work-related accident/ condition?** **YES NO**
   If yes – complete below **If no**, proceed to question 3.
   Name of employer _____
   Address of employer _____
   City/State/Zip _____
   Employer telephone (_____) _____ Employer contact name _____
   Occupation _____ Did you report the accident? YES NO
   Were you treated somewhere before today? YES NO
   If yes, where _____
   Worker's Compensation carrier name (if known) _____
   Worker's Compensation carrier address _____
   Worker's Compensation carrier City/State/Zip _____
   Claim number _____

   ***Failure to provide Work Comp. information will result in patient responsibility for payment of services rendered.**

3. **Was the accident/ injury due to a non-work related accident?** **YES NO**

4. **Is another party responsible for this accident?** **YES NO**
   If yes (compete below)
   Name of responsible party/ liability carrier _____
   Address of responsible party/ liability carrier _____
   City/State/Zip _____
   Responsible party/ liability carrier telephone _____

   If no, how shall we bill for these services? Pay today Bill my insurance

In the event this illness/accident/injury is determined by the worker compensation carrier or other liability carrier as not to be a result of a legitimate claim, I authorize the release of any medical information necessary to process claims submitted to my private insurance carrier. I authorize payment of medical benefits to Wisconsin Health Fund for services rendered. I understand that I am financially responsible for charges. I have read and understand my insurance coverage.

Signature_____ Date _____