INJURY QUESTIONNAIRE

Participant’s Name__________________________________________ ID#_____________________________________

Patient’s Name/Relationship__________________________________________

Provider(s) of Service_________________________________________________

Date(s) of Service_______________________________________________________

Type of Injury___________________________________________________________

Additional information is needed regarding this claim. Please complete this questionnaire and return it in order to avoid further delay in the processing of this claim.

When did the injury happen?_____________________________________________________

(Please give date and approximate time of injury)

Exactly where did the injury occur?_____________________________________________________

Please describe how the injury happened?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Is there another party responsible for this injury (automobile, homeowners insurance)? ___ Yes ___ No

If yes, please give the name and contact information for the responsible party.______________________________________________________________

Did the injury occur on the job? ______ Yes ______ No

If yes, was a Worker’s Compensation Claim filed? ____ Yes ____ No

________________________________________________________________________

Participant’s Signature ____________________________________________ Date ___________________________