Patient Accident and Injury Report
Please Print

Name_______________________________________ Birth Date ________________________
Address____
Social Security Number______-____-______
Date of Accident_______________ Time of Accident________________________________
Where did accident occur?____
Describe how accident happened in detail (very important)______________________________
____
____
____
Did weather, ice, snow, or lightning play any part in the accident? Yes/ No
Describe your symptoms in detail at the time of the accident (very important)_______________
____
____
____
____
Did youhave anysymptoms prior to the injury? Yes/No If so, describe here:________________
____
____
____
Have you been unable to work since injury? Yes/No List dates absent from work here: _____
____
Limited work list dates here:____
Return to work fully:____
Give names and addresses of all doctors consulted for this injury__________________________
____
____
Name and address of hospital for injury?____
Date admitted to hospital?________________ Discharged__________________________
Have you previously injured the present area of complaint? Yes/ No
If so, describe in detail ____
____
____
____
Have other disease or accidents affected your employment? Yes/No
If so, describe in detail? ____
Where you capable of working on an equal basis with others before the accident? Yes/No

Auto Insurance Name____
Address____
Policy/Claim #____________________Agents Name and phone #_________________________
Name and address of attorney involved in the case?_______________________________

Workers Compensation Insurance Name____
Claim #___________________________ Agents Name and Phone #_____________________
Your Employers Name____
Address ____
Name and address of attorney involved in case______________________________________
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