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INJURY INFORMATION QUESTIONAIRE

We **must** have the following information filled out for your insurance claim to be processed. If the following information is not filled out completely, we will have to ask you to pay your bill in full each visit, because insurance companies now require this information.

1. Patient's Name____

   If under 18, Responsible Party___________________________________

2. Date of Birth ______________________________ SS#_________________________

3. How did the injury occur?____

____

4. Date of injury____

5. Where did the injury occur____

6. Did this happen at work? Yes____________ No_______________

(if "Yes", please fill out the Workman's Compensation Information sheet)

7. Is this related to an automobile accident? Yes_____________ No________________

(if "Yes", please fill out the Auto Accident Information sheet)

8. Is there any other insurance involved? Yes______ No_______

(if "Yes", what insurance company?_______________________________________)

Signature of Member_____________________________________ Date________________