

INJURY QUESTIONNAIRE FOR PERSONAL INJURY

DATE: _____

1. NAME _____
2. DATE OF ACCIDENT _____
3. WHERE DID ACCIDENT HAPPEN? _____

4. HOW DID ACCIDENT HAPPEN? _____

5. WHAT INJURIES DID YOU SUSTAIN AS A RESULT OF THIS ACCIDENT?

6. IF INVOLVED IN AN AUTO ACCIDENT, WHAT CARE WERE YOU DRIVING?

7. WAS A POLICE REPORT FILED? _____
8. WAS AN AMBULANCE CALLED? _____ WERE YOU TRANSPORTED? _____
IF SO, WHERE? _____
9. WERE YOU HOSPITALIZED? _____ Where? _____
10. WERE YOU X-RAYED AT THE HOSPITAL? _____
11. DID YOU STAY AT THE HOSPITAL OR WERE YOU RELEASED THE SAME
DAY? _____
12. WERE ANY OTHER TESTS COMPLETED? _____
13. IF YOU WERE NOT HOSPITALIZED, HAVE YOU SEEN ANOTHER DOCTOR
REGARDING YOUR INJURIES PRIOR TO COMING TO THIS OFFICE? _____
IF SO, NAME OF DOCTOR: _____
14. WHERE ARE YOU EMPLOYED? _____
15. HAVE YOU LOST ANY TIME FROM WORK BECAUSE OF THIS ACCIDENT? ____
IF SO, WHEN? FROM _____ TO _____

INSURANCE/ATTORNEY QUESTIONNAIRE FOR PERSONAL INJURY

In order to update our records and complete claims processing, we are asking that you complete this questionnaire concerning your medical benefit or insurance coverage for this personal injury.

Date: _____

Name: _____ Date of Birth: _____

Date of Injury: _____ Social Security Number: _____

Name of patient's insurance company: (Auto, Homeowners, Medical, etc).

Insurance Company Address: _____

Policy Holder's Name: _____ Policy Number: _____

If you have retained an attorney, please provide the following information:

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Please identify if any other party may be responsible for these injuries:

Name: _____ Phone Number: _____

Address: _____

Insurance Company: _____ Phone Number: _____

Insurance Address: _____

Policy Holder's Name: _____

Policy Number: _____ Claim Number: _____

Adjuster's Name: _____

I, _____, also hereby authorize Dr. Max L. Denton or Dr. Coleen A.

Denton to release my insurance company, attorney, or adjuster any information acquired in the course of my examination or treatment.

Signature

Date