INJURY QUESTIONNAIRE

The purpose of completing this injury questionnaire is to assure that we have the needed information on file to submit your claims to insurance. Our policy is to submit all injury claims to your commercial insurance carrier. We do not bill any liability carriers with the exception of workers compensation. If you do not want charges submitted to your commercial insurance carrier, let us know and we will bill you directly.

Patient Name	Date of Birth
Date of Injury	Body part(s) injured
Describe how the injury occurred _____ _____ _____ _____	
Address of where injury occurred	State
City	Zip

ALSO COMPLETE THE FOLLOWING SECTION FOR WORK RELATED INJURIES

Important: We need the workers compensation section completed within 10 business days. If this section is not completed, claims will be submitted to your commercial insurance carrier. If you do not have health insurance, you are responsible for any and all charges incurred.

Employer Name		
Have you reported the injury to your employer? ☐ YES ☐ NO	Employer Address	
City	State	Zip Code
Employer's Phone #		
Workers Comp Carrier	Adjuster	Claim #
Address of Carrier		
City	State	Zip
Phone #		

Patient Signature: _____ Date: _____