OrthoArizona

Arizona Bone & Joint Specialists

Account#________________

PATIENT ACCIDENT INFORMATION

1. Patient Name ________________
   Address ________________
   City________________ State__________ Zip __________
   Home# __________ Cell#__________ Work# __________
2. How did your injury occur?
   ❑ MVA- motor vehicle accident
   ❑ Slip, fall or other ________________
   ❑ Off-road motor vehicle
   Date of accident: ________________
   Location: ________________
3. If you were injured in an MVA etc., who was at fault? ❑ Self ❑ Other Driver
   a. Name and address of the driver(s)
   ____
   ____
   b. Have you heard from the driver's insurance company? ❑ Yes ❑ No
   If yes, provide name/address of the company, the claims representative name and phone number.
   ____
   Claim# ________________
4. Was the accident investigated by the police? ❑ Yes ❑ No
   If yes, what city investigated __________ and were any citations issued? ❑ Yes ❑ No
   Who was cited? ❑ Self ❑ Other driver
5. If your injury occurred in a motor vehicle accident, did you have insurance on your vehicle? ❑ Yes ❑ No
   Name/address of insurance co. ________________
   Name of claim representative ________________
   Phone#________________ Claim# ________________
   (Our reason for asking these questions: Patient may have medical payments coverage, uninsured or under-insured motorist coverage which could respond to pay medical bills, co-pay's, deductibles, etc...)
6. Was any other person or business at fault in your opinion? ❑ Yes ❑ No
   Who/Whom? ________________
7. If you have an attorney please provide name, phone number, address, etc.
   ____
   ____
8. If you do not have an attorney; would you like us to give you the name of one that we work with? ❑ Yes ❑ No
9. Additional comments:________________

Patient Signature________________ Date form completed __________