

INJURY / ACCIDENT INFORMATION SHEET

DATE ___/___/___

PATIENT NAME _____ AGE _____

PROBLEM BEING SEEN FOR _____

HOW INJURY OCCURRED _____

DATE OF INJURY ___/___/___

WHERE INJURY OCCURRED _____

WOULD ANY OTHER INSURANCE COMPANY BE INVOLVED? _____

IF SO, NAME AND ADDRESS OF INSURANCE COMPANY: _____

ATTORNEY INVOLVED _____

NAME AND ADDRESS OF ATTORNEY _____

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize Upper Bucks Orthopaedic Association to release information of medical, hospital, and other related records and to discuss pertinent information with professionals involved in my case.

I hereby give my permission to share the information received with an insurance company or other program that is paying all or part of my medical fees. I agree that a Photostat of this authorization be accepted if necessary. I hereby authorize payment directly to Upper Bucks Orthopaedic Association the insurance benefits otherwise payable to me. Any balance is my responsibility.

DATE ___/___/___

NAME _____
(Signature)

ADDRESS _____
