

ACCIDENT/INJURY REPORT

Patient: _____ DOB ___/___/___ Account # _____

New patient _____ Est. pt. new injury _____ Referred by Dr. _____

*******PLEASE READ THIS STATEMENT*******

Per insurance company requirements, you may be required to fill out an accident/injury report prior to accepting your claim. To prevent a delay in acceptance of the claim or a possible denial please fill out this form and sign it below. With out a signature below your insurance company will not accept this form and you may subsequently be billed if your insurance denies payment.

If the problem you are being seen for was not from an accident please state time of onset and a brief statement explaining your problem.

Problem you are being seen for _____

Date of onset or injury ___/___/___ Work injury ___ Auto accident ___ Sports injury ___ Other ___

Where did the injury/problem occur _____

Describe how the problem began _____

Were you taken to emergency room Y/N. Which one _____ Taken by ambulance Y/N.

If no how long after injury _____. By what mode of transportation _____

You were seen in ER for what symptoms _____

X-rays taken of _____ Were you casted/splinted/braced.

Were other tests preformed Y/N. If Yes what _____

If you did not go to ER, where did you first go _____

PATIENT SIGNATURE _____ DATE ___/___/___

PAST MEDICAL HISTORY

check yes if you have had any of the following

	yes	no		yes	no
Diabetes			Hypertension (high blood pressure)		
Heart disease			Chest pain		
Shortness of breath			Asthma/breathing problems		
Stroke			Thyroid problems		
Ulcers/stomach pain			Constipation/diarrhea (for unknown reason)		
Migraine headaches			Depression/other mental disorder		
Fracture/dislocation			Other		

check yes if any member of your immediate family has had any of the following

	yes	no		yes	no
Diabetes			Hypertension		
Heart problems			Breathing problems		
Anemia			Arthritis		
Mental illness			Cancer		

List all surgeries and the year they were done.

What medications are you taking, and which doctor prescribed it for you.

List any allergies to drugs and your reaction to it.

Men only

When was your last prostate exam? _____ Was it normal? _____ When was your last hernia exam? _____ Was it normal? _____

Women only

When was your last pap exam? _____ Was it normal? _____ Are your menstrual periods regular? _____ If not did they become irregular after the injury? _____ Are you postmenopause? _____ Have you had a tubal ligation? _____ year? _____ Hysterectomy? _____ year? _____ Are you on estrogen replacement? _____

Do you smoke? yes no If yes how many packs per day? _____ Do you use other tobacco products? yes no Do you drink alcohol? yes no How much per day? _____

Describe any symptoms on the appropriate line. Example: headaches after the accident sharp constant; now dull and throbbing, comes and goes.

<u>SYMPTOMS EXPERIENCED</u>	<u>AFTER THE ACCIDENT</u>	<u>NOW</u>
<u>HEADACHES</u>		
<u>VISION PROBLEMS</u>		
<u>DIZZINESS</u>		
<u>MEMORY PROBLEMS</u>		
<u>LOSS OF COORDINATION</u>		
<u>SLEEP DISORDERS</u>		
<u>ANXIETY</u>		
<u>DEPRESSION</u>		
<u>MOOD SWINGS</u>		
<u>NUMBNESS (where)</u>		
<u>PAIN (where)</u>		
<u>OTHER</u>		
<u>OTHER</u>		
<u>OTHER</u>		

Indicate with an X the areas of your body injured

