ACCIDENT DETAIL QUESTIONAIRE

Today's Date: _____ Date of Accident: _____

Patient Name: _____

Physician you are seeing: ☐ Dr. Kevitch ☐ Dr. Chung ☐ Dr. Jan

Is this a: ☐ Workman's Compensation Claim or ☐ Auto Insurance Claim?

If this is going through you medical insurance, please disregard the insurance box below*

Insurance Company: _____

Insurance Company Claims Address: _____

Claim #: _____

Claim Adjuster Name / Phone Number _____

Please answer all of the following questions regarding the accident in detail. Failure to provide complete information could result in a claim processing delay. Completion of this form is not a guarantee of payment from your insurance company. Any office visit fees are ultimately the responsibility of the patient.

Location of accident / injury: _____

What were you doing when said accident / injury occurred? _____

_____

What caused the accident / injury? _____

_____

What was the result / diagnosis of the accident / injury? _____

If this is a result of an auto accident, were you a: ☐ Driver ☐ Passenger or ☐ Pedestrian?

If you were inside the vehicle when the accident occurred, were you wearing your seatbelt? ☐ Yes ☐ No

Please list the types of all of the vehicles involved in the accident: _____

_____

Signature of Patient*: _____ Date: _____

*Please have parent/guardian sign if patient is a minor.