



Accident/ Injury Questionnaire

Patient Name _____ Birthdate _____
 Patient Address _____
 City _____ State _____ Zip _____
 Telephone (_____) _____ Social Security # _____

1. **Is today's visit related to an accident/ injury?** YES NO
 Date of accident ____/____/____ Time of accident _____
 Location of accident _____
 Please describe the accident/ injury _____

2. **Was the accident/ injury due to a work-related accident/ condition?** YES NO
If yes – complete below **If no**, proceed to question 3.
 Name of employer _____
 Address of employer _____
 City/State/Zip _____
 Employer telephone (_____) _____ Employer contact name _____
 Occupation _____ Did you report the accident? YES NO
 Were you treated somewhere before today? YES NO
 If yes, where _____
 Worker's Compensation carrier name (if known) _____
 Worker's Compensation carrier address _____
 Worker's Compensation carrier City/State/Zip _____
 Claim number _____

*Failure to provide Work Comp. information will result in patient responsibility for payment of services rendered.

3. **Was the accident/ injury due to a non-work related accident?** YES NO
 4. **Is another party responsible for this accident?** YES NO
 If yes (complete below)
 Name of responsible party/ liability carrier _____
 Address of responsible party/ liability carrier _____
 City/State/Zip _____
 Responsible party/ liability carrier telephone _____

If no, how shall we bill for these services? Pay today Bill my insurance

In the event this illness/accident/injury is determined by the worker compensation carrier or other liability carrier as not to be a result of a legitimate claim, I authorize the release of any medical information necessary to process claims submitted to my private insurance carrier. I authorize payment of medical benefits to Wisconsin Health Fund for services rendered. I understand that I am financially responsible for charges. I have read and understand my insurance coverage.

Signature _____ Date _____