CONFIDENTIAL QUESTIONAIRE – WC/NF Supplement

PATIENT INFORMATION

NAME ______________________________ SS No.: ______________________________

WORK COMP INFORMATION

EMPLOYER______________________________

OCCUPATION______________________________

ADDRESS______________________________

CITY______________________________ STATE______________ ZIP__________

PHONE______________________________ FAX______________________________

INJURY/ACCIDENT INFORMATION

ACCIDENT TYPE: ☐ AUTO ☐ WORK ☐ SLIP & FALL ☐ OTHER______________________________

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER______________________

DATE OF INJURY____________ IF AUTO, WERE YOU: ☐ DRIVER ☐ PASSENGER ☐ PEDESTIAN ☐ ____________

POLICY #____________________ CLAIM/CC #____________________ WCB #____________________

DESCRIBE ACCIDENT/INJURY______________________________

____

____

____

WAS INJURY REPORTED: ☐ YES ☐ NO TO WHOM______________________________

WERE YOU HOSPITALIZED ☐ YES ☐ NO WHERE______________________________

X-RAYS TAKEN ☐ YES ☐ NO BY WHOM______________________________

WERE YOU WORKING AT TIME OF ACCIDENT ☐ YES ☐ NO

DATES LOST FROM WORK______________________________

OTHER DOCTORS SEEN FOR THIS INJURY______________________________

____

NAME OF ATTORNEY______________________________ PHONE______________________________

INSURANCE INFORMATION

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER______________________

INSURED NAME______________________________ Insured Employer______________________________

INSURANCE COMPANY______________________________

ADDRESS______________________________

PHONE (_______)______________________________ POLICY No.______________________________

SECONDARY INSURANCE Co.______________________________

ADDRESS______________________________

PHONE (_______)______________________________ POLICY No.______________________________