

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME: _____ **TODAY'S DATE:** ____/____/____

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM.
WE MUST HAVE "BOX 1: CONDITION OR DATE OF INJURY" COMPLETED TO FILE YOUR CLAIM.

1. Please check: CONDITION INJURY INJURY DATE: ____ / ____ / ____ (ON OR ABOUT)

THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary) _____

2. Did the injury occur during work? YES NO

3. Were you clocked in? YES NO

4. Were you at lunch? YES NO

THIRD PARTY LIABILITY

5. Is there a possible third party liability? YES NO

(INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC.?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance may deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "**non-covered**" service and may make me personally liable for the charges incurred.

SIGNATURE: _____ **TODAY'S DATE:** ____/____/____

(RESPONSIBLE PARTY)