

ORTHOPAEDIC SPECIALISTS OF CHARLESTON, P.A.
2093 HENRY TECKLENBURG DRIVE
CHARLESTON, SC 29414
(843) 958-2500
TAX ID # 57-1059791

ACCIDENT/INJURY INFORMATION

RE: PATIENT NAME: _____
SUBSCRIBER NAME: _____
SUBSCRIBER INSURANCE ID#: _____
PATIENT SS#: _____
CHART #: _____

Are you being treated as a result of an accident or injury to which a third party is responsible? _____ (YES or NO)

If NO, please sign and date the bottom.

If YES, please provide the following information:

Describe the accident or injury and how it occurred:

Date _____ City or County _____

Did the injury occur as a result of a motor vehicle or other type of accident that was caused by someone else? _____ (YES or NO)

If YES, please provide the name and address of the person causing the injury and their insurance company.

PERSON	INSURANCE COMPANY
_____	_____
_____	_____
_____	_____
_____	Policy/Claim # _____

Was this treatment necessary as a result of injury while on the job? _____ (YES or NO)

If YES, has a claim been made for Worker's Compensation? _____ (YES or NO)

If YES, provide the name of the Worker's Compensation Carrier: _____

Signature

Date

Phone #