

Patient's HPP Guarantor #: _____ Patient's HPP Acct#: _____



Orthopaedic Specialists of Charleston

Patient Information – Injury and/or Pain Form

This information is required by most insurance carriers when medical services are related to any Accident/Injury/Incident.

To Be Filled Out by Patient: Injury/Accident/Incident Information

Patient's Name: _____ Date of Birth: _____
Date of Accident: _____

OR the Approx. Date Symptom(s)/Pain first began: _____

Where Accident Occurred: (Please check one)

- Work Related (Give Employment Information Below)
 Auto Accident State: _____ Note: If auto accident, the State in which the accident occurred is required
 Home
 Other, Please Specify: _____

Brief description of how accident/incident or onset of symptoms occurred and the affected body part:

Example: Twisted ankle/foot after stepping in hole in yard at home yesterday at approx. 5pm

If not work related, please skip to signature section.

Employment Information for Work Related Injury:

This information is required for all work related injuries when a Worker's Compensation Insurance Carrier should be billed. Please give the staff any paperwork you received from your employment and/or their worker's compensation insurance, so we may file your services properly. Without the correct billing information, for a work related injury, you may be held responsible for payment.

Name of Employer: _____

Name of Employer Contact: _____ Contact Phone: (_____) ____ - _____

Work Comp Policy/Claim #: _____

Name and address of Work Comp Carrier: _____ If Dept of Labor*, Diagnosis Code(s): _____

*Provide letter from DOL. The DOL should have sent you a letter approving your claim and assigned a diagnosis.

Name of Adjuster: _____ Phone # (_____) ____ - _____

Name of person providing information: _____ Relationship to Patient: _____

To the best of my knowledge, the information provided above is correct.

Patient's Signature: _____ Date: _____