



Date of Visit: \_\_\_\_\_

**Patient Information for Initial Accident Report & Work-Related Visits** Receptionist initials: \_\_\_\_\_

Employer Name: _____	Employer Phone: _____
Address: _____	Employer Fax: _____
City: _____ State: _____ Zip: _____	Authorized by: _____
Employer Insurance Company: _____	Insurance Phone: _____
Claims Adjuster: _____	Insurance Fax: _____
Address: _____	Policy Number: _____
City: _____ State: _____ Zip: _____	Claim Number: _____

Patient's Name: _____	Phone: _____	Cell /Pager: _____
Address: _____	City: _____	State: _____ Zip: _____
Social Security: _____	Date of Birth: _____	Age: _____ Sex: [ ] M [ ] F
If patient is a minor, please indicate parent or legal guardian: _____		
Emergency Contact: _____	Phone: _____	Relationship to Patient: _____
Address: _____	City: _____	State: _____ Zip: _____

Patient's Health Insurance Carrier: _____	ID# _____	CoPay: _____
Insurance Address: _____	City: _____	State: _____ Zip: _____
Name of Insured: _____	Relationship to Patient: _____	SS# of Insured: _____ Primary Care: _____

Date of Injury _____	Approximate Time _____	Patient's Shift time _____	Patient's work # _____
Part[s] of body injured _____			
Nature of the problem [i.e. cuts, bruises, etc.] _____			
Describe the injury and how it occurred _____			
_____			
Were there any witnesses to this episode? [ ] Yes [ ] No If yes, who? _____			
Have you already received treatment for this injury? [ ] Yes [ ] No If yes, where and what type of treatment? _____			
_____			
In the past, have you injured the same part of the body? [ ] Yes [ ] No Please describe if the answer is yes: _____			
_____			
Job Title and Responsibilities: _____			
Do you use any personal protective equipment at work [i.e. steel boots, hearing and/or eye protection, respirator]? [ ] Yes [ ] No Describe: _____			
_____			
If you wear personal protective equipment at work, were you wearing it at the time you were injured? [ ] Yes [ ] No			
Do you work with any hazards? [ ] Yes [ ] No If yes, please specify: _____			
_____			

I hereby authorize Immedicenter to release all information including, without limitation, initial accident report, diagnosis, records of treatment rendered to me, to my employer and/ or my employer's Workers Compensation carrier, as required for reimbursement purposes.	
I certify that all of the information I provided is accurate to the best of my knowledge.	
In the event that my employer denies authorization for treatment, I hereby acknowledge and understand that I am responsible for all medical services rendered to me at Immedicenter. If the patient is a minor, his/her guardian should sign below.	
Signed: _____	Date: _____