RTH Plastic Surgery

AUTO ACCIDENT / WORKMAN'S COMP INFORMATION SHEET

PATIENT NAME _____ DATE _____

CLAIM # _____

Work Related ◯ Yes ◯ No

1. If yes, have you filed an accident report with the employer? ◯ Yes ◯ No
2. Date and time of accident _____
3. Where did the accident happen? _____
4. Please describe the accident _____

_____

_____

5. Workman Comp | Send Bill to _____
   Name Phone

   _____
   Address City State Zip

Auto Related ◯ Yes ◯ No

1. If yes, have you filed a claim with your insurance company ◯ Yes ◯ No
2. Date and time of accident _____
3. On what date did the patient first have medical attention or treatment for this injury? _____
4. Please describe the accident _____

_____

_____

5. Are you pursuing or do you intend to pursue any type of legal action for the injury? ◯ Yes ◯ No

   If yes, Attorney _____
   Name Phone

   _____
   Address City State Zip

Coordination of Benefits Automobile Insurance Information

1. Name of Vehicle's Insurer _____
2. Name of Policyholder _____ Policy # _____
3. Agent _____
   Name Phone

   _____
   Address City State Zip

I authorize the release of any medical information necessary to process claims incurred by this accident. I also understand that in the event that the carrier denies payment that I am responsible for all medical expenses.

Patient of Insured Signature _____ Date _____