Auto & Workers' Compensation

Colorado Springs Family Practice

Today's Date_____

Patient Name_____ Date of Birth_____

Date of Accident_____ Where Injury Occurred(State)_____

Type of Accident: (circle) AUTO / WORK-RELATED / OTHER_____

Chief Complaint_____

_____

Auto Insurance Information

Insurance Company_____ Policy #/ ID_____

Claim No._____ Policy Holder's Name_____ Phone_____

Claim's Address_____
Street City/State Zip

Adjuster/Representative Name_____

Workers Compensation Information

Occupation_____ Responsible employer's name_____

Employer Address_____
Street City/State Zip

Employer Phone (_____)_____ W/C Insurance_____ Claim No._____

Explanation of how the injury/problem occurred_____

_____

_____

_____

Anatomical Area of Injury_____ Side: RIGHT LEFT

Are you involved in competitive sports? (circle) YES NO Type_____

Occupational Activities_____

List all medications you are presently taking_____

_____

List any drug allergies_____

_____

_____ _____

Patient Signature (Parent Guardian/Authorized person if Minor) Today's Date