

ASSOCIATED ORTHOPEDICS AND SPORTS MEDICINE

Universal Injury, Condition and/or Accident Statement

Patient Name: _____

Date: _____

Please complete the following statement. Most insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury or condition and sign IN Box 4. We must have Box 1 "Date of Injury or Condition" completed to file your claim.

1

Date of Injury or Condition: ____ / ____ / ____ (COMPLETE DATE ON OR ABOUT)
DATE IS REQUIRED FOR INSURANCE FILING

→ **The following details are required IF this was an INJURY:**

Where did injury occur: _____
(e.g. Auto, home, parking lot, friend's house, etc.; if at work, complete Box 2)

How did injury occur (brief summary): _____

2

Was injury or condition work related? YES NO < (Required please answer)

If YES then.....

Name of Employer: _____

Contact/Supervisor: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

3

Is there a possible third party liability statement (e.g. Auto, Homeowners, Property): YES NO

If YES then.....

Third Party Contact Name: _____ Phone: _____

Company: _____ Claim #: _____

4

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient Signature: _____

Date: _____