INJURY QUESTIONAIRE

The following questions should be addressed for each office visit that may be accident or injury related.

1. **DATE OF ACCIDENT** ______ /______ /__________ (mm/dd/yyyy)

2. **WHERE DID THE ACCIDENT OCCUR?**
   - ☐ At Home – Patients own Residence
   - ☐ Work, Place of employment
   - ☐ Commercial business location
   - ☐ Other public building ______________________________
   - ☐ Recreation area, someone else's home, school, church, other ______________________________

3. **HOW DID THE ACCIDENT OCCUR?**

   ____

4. **DID THE ACCIDENT OCCUR IN, ON, OR AROUND AN AUTOMOBILE?** ☐ YES ☐ NO

   If YES, complete the following:

   Name of auto insurance company: ______________________________

   Address: ______________________________

   Phone number: (________) ________ - ____________________

   Policy number: ______________________ Claim number: ______________________

5. **ANOTHER PARTY RESPONSIBLE FOR THIS ACCIDENT?** ☐ YES ☐ NO

   If YES, complete the following:

   Name of employer: ______________________________

   Address: ______________________________

   Phone number: (________) ________ - ____________________

6. **IF THIS INJURY IS WORK RELATED, HAVE YOU COMPLETED A *First Report of Injury* FORM?** ☐ YES ☐ NO

   If NO, please ask the front desk for the form.

If my injury resulted from any activities as indicated above, and I choose to not submit charges to any third party, I will be financially responsible for charges incurred. I understand that medical insurance coverage will not usually cover services related to injuries which may involve employment, an automobile, or another responsible third party.

COMPLETED BY: (print name) ______________________________ DATE:______/_______/__________

SIGNATURE ____

DANIEL HUFF, DPM • ANDREW BURGON, DPM

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