Absolute Foot Care Specialists
Injury Accident Report Form

Today's Date:_____

Patient name:_____

Health Insurance:_____ Insurance ID#:_____

Date of service(s) of treatment here:_____

Is the problem you are seeking treatment for related to an injury or accident: ❒ Yes ❒ No
(If No, skip to the bottom of the page, sign and date the form)

Date of injury? _____/_____/_____

Were you injured on the job? ❒ Yes ❒ No
Were you injured at home? ❒ Yes ❒ No
Were you injured in a car accident? ❒ Yes ❒ No
Were you injured as the result of another person or businesses negligence? ❒ Yes ❒ No

Have you notified your employer of your injury? ❒ Yes ❒ No
Was a C-4 form filled out? ❒ Yes ❒ No

Employer at the time of injury?_____

Are you currently working? ❒ Yes ❒ No

Describe in detail how the injury occurred?_____
_____
_____

Location of injury / accident:_____

What part(s) of the body was injured?_____

Was a police report completed and filed? ❒ Yes ❒ No

If it was a motor vehicle accident, who caused or may have caused it?
_____
Name Address Insurance Company

Have you notified your car insurance company yet? ❒ Yes ❒ No

Auto Insurance Co. & Address:_____

Policy#:_____ Claim#:_____

Adjuster Name:_____ Phone #:_____

Do you have an Attorney? ❒ Yes ❒ No

Attorney Name: _____ phone:_____

Address:_____

I hereby verify that the above information is true and complete to the best of my knowledge.

_____ _____
Patient/Parent/Guardian Signature Date