Atlantic Medical Imaging- Accident/Injury Questionnaire

Patient's Name _____ Date of Birth_____

Date of Service _____

The following information is required in order to bill your insurance carrier for services provided today.

1. Is today's exam related to an: ❑ Workers' Compensation Injury OR ❑ Auto Accident Injury

2. Name of AA or WC Insurance Company. _____

3. Claim Number. _____

4. Claim Adjuster's Name. _____

5. Claim Adjuster's Telephone Number. _____ Extension. _____

6. Name of Medical Insurance._____

7. Medical Insurance ID Number. _____

8. On what date did the accident/injury happen? _____

9. In what state did the accident happen?_____

10. Where did the accident happen?_____

11. Have you retained an attorney? ❑ Yes ❑ No

If YES, name of your attorney. _____

12. Name of doctor(s) treating you for this injury. _____

13. Name of Worker's Comp Employer: _____

I authorize the release of my medical information to any insurance company, physician and /or attorney involved in my care.

Patient Signature _____ Date _____