ORTHOPEDIC SPECIALISTS OF SW FLORIDA
2531 CLEVELAND AVENUE, SUITE 1
FORT MYERS, FLORIDA 33901
TELEPHONE: (239) 334-7000
FAX: (239) 334-7070

Patient: _____ **Date of Service: _____**
Identification # (health ins.): _____ **Group #: _____**
Provider: _____

Accident/Injury Detail- (this form must be completed, signed and dated)

Many insurance companies require accident/injury details after they receive our claim. Please answer the following questions and explain how this accident/injury occurred.

Is this claim related to an accident? ___ Yes___ No

If **yes**, what was the date of this accident? _____

If **no**, please describe your symptoms, when they started and the manner in which they started:
_____
_____

If Auto, Motorcycle or "Other Accident" please answer the following:

___ Auto ___ Motorcycle ___ ATV/Dirt Bike ___ Bicycle ___ Other

Were you the _____ driver or _____ passenger?
Do you own the vehicle? ___ Yes___ No
If motorcycle related, do you have PIP insurance that would cover medical expenses relating to this accident?___ Yes ___ No
Has a claim been made with your auto insurance carrier? ___ Yes___ No
Provide description of how accident occurred: _____
_____
_____

If Work related, please answer the following:

Name of employer at the time of injury: _____
Are you self employed? ___ Yes ___ No
Do you receive a W-2 (employee) or 1099 (subcontractor) from this employer at year end? ___ W-2 ___ 1099
Have you filed a Workers' Compensation claim? ___ Yes ___ No
Has the employer or the workers' compensation carrier accepted or denied liability? ___ accepted ___ denied

Attorney Information
Have you sought the assistance of an attorney relating to this accident/injury? ___ Yes ___ No
If yes, please provide: Attorney's name:_____
Attorney's address: _____
Attorney's phone: _____

To the best of my knowledge the above information is true, accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to my health insurance company, _____, all records necessary for processing claims filed by me or on my behalf.

Signature: _____ Date: _____