# Personal Injury Patient Questionnaire

Name: ______________________________ Date of Injury: ____________________

Address: ____________________________________________________________

City: ________________________ State: __________ Zip Code: _______________

Home Phone: _______________________ Cell Phone: _______________________

Email Address: _______________________________________________________

Birthday: ___________________ Age: _________ SSN: ______________________

Circle One: **Married** **Single** **Widowed** **Divorced** **Separated**

How did you hear about our office? _________________________________________

Occupation: __________________________________________________________

Employer: ___________________________________________________________

Work Phone: _________________________________________________________

Did this injury occur during the course of your job duties? _____Yes _____No

Insurance Company Name: _______________________________________________

Policy Number: _______________________________________________________

Claim Number: _______________________________________________________

Insurance Company Phone Number: _________________________________________

Adjuster for this Claim: _________________________________________________

Please list any current medications: _______________________________________

______________________________________________________________________

Please list any allergies to medications: ___________________________________

I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the doctor to treat my condition as he deems appropriate.

Signature: ______________________________________ Date: ____________________