Accident/Liability Claim Information

Patient Information

Name_____Birthdate_____

Address_____

_____Telephone_____

Employer Information (For Worker Compensation Claims Only)

Employer_____Telephone_____

Employer Address_____

Contact Person_____

Insurance Carrier for This Injury/Accident

Insurance Carrier_____

Carrier Address_____

Carrier Telephone_____Claim #_____

Injury/Accident Information

Date of Injury_____Time_____AM or PM

Place of Injury_____

To whom was Accident Reported _____

Description of Accident_____

Have you lost time from work?_____How Much?_____

Have you seen other doctors or had previous treatment for this condition? Describe._____

Payment Agreement-Release of Information

I understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment in the event that my claim for compensation/liability benefits is denied. I hereby authorize The Medical Group of Kankakee County to release any information acquired in the course of my examination or treatment to insurance company or other health care providers.

_____ _____

Signature Date