Charles Bailey, M.D.

Screening Form for Injuries/Accidents

Patient Name: _____ HIC#: _____

Is ***this*** illness or injury due to an accident? YES NO

If yes, circle the type of accident and complete the information below:

Motor Vehicle Accident *Work Related Accident* *Slip and/or fall* *Other Accident*

Date of Accident: _____

Accident Details: _____

_____

Is there auto, worker's compensation or other insurance which covers this accident? YES NO

If yes get complete the information below:

Insurance Name: _____

Insurance Address: _____

Claim Number: _____

Adjustor Name: _____

Does the patient plan legal action at this time? YES NO

Patient Signature: _____ Date: _____