ACCIDENT INFORMATION

Patient Name:_____

Type of Injury:_____

Date of Accident:_____

How did Accident Occur?_____

_____

Where Did Accident take place?_____

Third Party Insurance
Company_____

Address:_____

Pollicy Number:_____Claim Number:_____

Insured Name:_____

Agent/Contact:_____Phone:_____

I authorized payment of medical benefits to Jefferson Orthopedic Clinic for services rendered. Should my health insurance company or third party not pay charges associated with the above Accident, I understand that I will be financially responsible for payment on this account. I hereby Authorize Jefferson Orthopedic Clinic to release all information regarding my medical care to the above third party for all charges related to this accident date.

_____ _____

Date Signature