OrthoIdaho

2240 EAST CENTER STREET
POCATELLO, IDAHO 83201

DATE OF INJURY: ______________________________

WHERE DID THE ACCIDENT/INJURY OCCUR? ______________________________

DESCRIBE BRIEFLY HOW THE ACCIDENT/INJURY OCCURRED AND WHAT PART OF THE BODY WAS AFFECTED:

____
____
____

° Was the injury sustained while performing work required by your employer? ________
- If yes, name of employer: ______________________ Phone #: ________
- Name of Worker's Compensation carrier ______________________
- Claim #: ______________
- Adjuster's name: ______________________
- Phone #: ______________

° Was the injury the result of a motor vehicle accident? ______________
- In what State did the accident occur? ______________
- If yes, are you covered for medical expenses through your automobile insurance policy? __________
- Name of insurance company: ______________________
- Claim adjuster's name: ______________________
- Phone #: ______________
- Claim #: ______________

° Is there an attorney involved with your accident?
- If yes, name of attorney: ______________________
- Phone #: ______________

PRINT PATIENT NAME: ______________________ DOB: __________
SIGNATURE: ______________________ Date: __________

Home Phone: ______________________ Work Phone: __________