Foot & Ankle
Center of Arizona

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Accident Report

PATIENT'S NAME: _____

INSURED'S NAME: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

INSURANCE GROUP NUMBER: _____ INSURANCE PLAN NUMBER_____

DATE OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

WERE YOU SEEN AT AN EMERGENCY ROOM/URGENT CARE? ☐ YES ☐ NO

IF YES, WHAT HOSPITAL?_____ WHEN WERE YOU SEEN?_____

HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN/MEDICAL PROFESSIONAL FOR THIS INJURY? ☐ YES ☐ NO

IF YES, WHO DID YOU SEE? _____ WHEN WERE YOU SEEN? _____

IS THE ACCIDENT WORK-RELATED? ☐ YES ☐ NO IF YES, HAS IT BEEN REPORTED? ☐ YES ☐ NO

IF YES, WHAT IS THE CLAIM NUMBER?_____

IS THE INJURY A RESULT OF A CAR ACCIDENT? ☐ YES ☐ NO

HAVE YOU RETAINED AN ATTORNEY? ☐ YES ☐ NO

IF YES, NAME OF YOUR ATTORNEY:_____ PHONE:_____

NAME AND PHONE NUMBER OF THE ADJUSTER: _____

ACCIDENT DESCRIPTION (PLEASE BE SPECIFIC): _____

_____

_____

WE REQUIRE A CREDIT OR DEBIT CARD ON FILE WITH OUR OFFICE IF WE WILL BE TREATING YOU FOR AN ACCIDENT INJURY. YOU WILL BE ASKED FOR A CREDIT CARD AT THE TIME YOU CHECK IN AND THE INFORMATION WILL BE HELD SECURELY. WHEN YOUR PORTION OF THE BILL IS DETERMINED, WE WILL CHARGE YOUR CARD AND A COPY OF THE RECEIPT WILL BE PROVIDED TO YOU. PLEASE BE PREPARED TO COVER THE FEES FOR EACH VISIT AT THE TIME OF TREATMENT.

INSURED/PATIENT'S SIGNATURE: _____ DATE: _____