480.342.9999

Foot & Ankle
Center of Arizona

WWW.ARIZONAFOOT.COM

Accident Report

Insured's name: ____

Insured's Social Security number: ____

Insurance group number: ____

Insurance plan number: ____

Patient's name: ____

Date of accident: ______________

Location of accident: ____

Is the accident work-related? ____

If yes, has it been reported? ____

If yes, what is the claim number? ____

Name and phone number of the adjuster: ____

Is the injury a result of a car accident? ______________________________________

Accident description (please be specific): ____

____

____

____

Have you retained an attorney? □ Yes □ No If yes, Name: ______________________ Phone: __________________

Insured/patient's signature: ____ Date: ____________________