CODDINGTON MEDICAL FAMILY PRACTICE

Motor Vehicle Accident/Worker's Comp Injury

Patient Name:________________________ Date of Birth:____________________

Date of Accident/Injury:____________________

Location of Accident/Injury (Please Be Specific):______________________________

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Details of Injury/Accident:____

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Insurance:____

Claim #:____

Adjustor Name:____

Adjustor Phone #:____

Adjustor Fax #:____

YOU ARE RESPONSIBLE FOR WHAT INSURANCE, INCLUDING MEDICARE, MEDICAID, MOTOR VEHICLE INSURANCE OR WORKMAN'S COMP, DOES NOT PAY

This may include (but is not limited to) lab work (LabCorp/pathology medical), X-rays (AMI Radiology Associates), and anything that requires a separate bill.

Patient Signature:______________________________ Date:________________

Clinic Rep. Signature:___________________________ Date:________________