INJURY INFORMATION

PATIENT INFORMATION

Name_________________________________ Date of Birth__________ Soc. Sec.#_____________ Date_________

Address____ Telephone____________ Occupation_____________

EMPLOYER/FACILITY

Employer/Facility____ Telephone___________________

Address____

Injury Verified By (For Office Use) ______________________________ Contact Person_______________________

THIRD PARTY INSURANCE (FOR OFFICE USE)

Insurance Carrier_______________________________ Carrier Address____________________________

Carrier Telephone_________________________ Coverage Verified By_____________________________________

Adjuster's Name________________________________ Claim Number______________________________________

INJURY INFORMATION

Date of Injury_____________ Time of Injury_______________ AM PM Place of Injury_______________________

Did you report your accident? Yes No Person you reported accident to_____________________________________

Give full description of how accident happened____

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Have you lost time from work? Yes No How much?____

Other doctors seen for this condition: Doctor's Name__________________________Diagnosis__________________

Were X-Rays Taken? Yes No Other Tests? Yes No

If yes, by whom? Please list test(s) and result(s)____

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AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claims for my injury are denied. I am including a copy of my health insurance card for future reference.

Patient's Signature____ Date____________________

This Notice of Injury is pursuant to SDCL 62-7-11.

I further select Dr.______________________ as my treating Physician pursuant to SDCL 62-4-43, to treat me for my injury as described above. Dated this_____________ day of__________________, 201___.

__________________________________   __________________________________

Witness   **Employee Signature**