Name:_____ **DOB:**_____

Allegany Plastic Surgery

Workers compensation / Auto Accident / Injury

(If you are seeking treatment because of an accident/injury sustained while on the job, please complete this section.)

Workers Compensation Injury

Employer: _____ *Phone:* _____

Did you file an accident/injury report? YES / NO ☐ ☐ *Date of Injury/accident:* _____

Workers Compensation Carrier: _____

Address: _____*City* _____ *State* _____ *Zip code* _____

Name of Adjuster: _____ *Phone #* _____

Claim # _____ *Type of Injury* _____

(If you are seeking treatment as a result of an auto accident, please complete this section.)

Auto Accident/Insurance

Insurance Company Name: _____

Address: _____*City* _____*State* _____*Zip code*_____

Date of Accident: _____ *Where you the **Driver** or **Passenger (please circle)***

Have you filed a claim? YES / NO *Claim #:* _____

Name of Adjuster: _____ *Phone:* _____

State accident Happened in _____ *Type of Injury*_____

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*(If you are seeking treatment as a result of an **Injury** or related to **old Injury,** please complete this section.)*

Injury or old injury

Is this visit related to current injury? YES / NO ☐ ☐ *Date of Injury* ____/____/____

Is this visit related to old injury? YES / NO ☐ ☐ *Date of injury* ____/____/____

Where did injury occur (Be Specific) EXAMPLE: kitchen, yard, garage, etc

_____

_____

How did injury occur (Be Specific) _____

_____