Name:	DOB:

Allegany Plastic Surgery

Workers compensation / Auto Accident / Injury

(If you are seeking treatment because of an accide Workers Compensation Injury	ent/injury sustained while on the job, please complete this section.)	
Employer:	Phone:	
Did you file an accident/injury report? YES/	NO Date of Injury/accident:	
Workers Compensation Carrier:		
Address:City	StateZip code	
Name of Adjuster:	Phone #	
Claim # Type	of Injury	
(If you are seeking treatment as a result of an auto Auto Accident/Insurance Insurance Company Name:		
Address:City	StateZip code	
Date of Accident: Have you filed a claim? YES / NO	Where you the Driver or Passenger (please circle) Claim #:	
Name of Adjuster:		
State accident Happened in	Type of Injury	
(If you are seeking treatment as a result of an Inju Injury or old injury	ury or related to old Injury, please complete this section.)	
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) EXAMPL	LE: kitchen, yard, garage, etc	
*How did injury occur (Be Specific)		