ELIZABETHTOWN FAMILY HEALTH CENTER
300 Maytown Road
Elizabethtown, PA 17022
717-367-1430
717-367-2895

INJURY REPORT FORM

NAME:_____AGE:_____DOB:_____
ADDRESS:_____
SS#:_____PHONE#:_____

ACCIDENT REPORT

TODAY'S DATE:_____DATE OF INJURY:_____
ACCIDENT DESCRIPTION:_____
_____
_____
DISABLED FROM_____TO_____

WORKER'S COMP CLAIMS

EMPLOYER'S NAME:_____PHONE#:_____
ADDRESS:_____
WAS INJURY REPORTED AT WORK?:_____TO WHOM?:_____
DO WE HAVE EMPLOYER'S PERMISSION TO TREAT YOU?_____
INSURANCE COMPANY:_____
INSURANCE ADDRESS:_____
POLICY #:_____CLAIM #:_____

AUTO CLAIMS

INSURANCE COMPANY:_____
NAME OF INSURED:_____RELATIONSHIP:_____
INSURANCE ADDRESS:_____
POLICY #:_____CLAIM #:_____
POLICE NOTIFIED?:_____ SEAT BELT USED?:_____

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize Elizabethtown Family Health Center to furnish and/or release any information necessary to insurance carriers concerning my injury/illness, to process my insurance claims acquired in the course of my treatment, to allow a copy of my signature to be used to process my insurance claim. I understand that I am responsible for the charges should this claim be denied by Worker's Comp Insurance/Auto Insurance/Third Party Liability.

PATIENT'S SIGNATURE_____DATE_____
WITNESS_____DATE_____