PROBLEM RELATED INFORMATION

Patient Name: _____ **MRN:** _____

Provider: _____ **DOS:** _____

A) In order to correctly bill insurance or work comp, we need the following information:

Was this an injury or an onset of symptoms? Accident/Injury Onset of Symptoms

B) If this is not an accident or injury, please skip to (C)

1) Body Part _____
2) Side of Injury/Accident, if applicable? Right Left Both
3) What type of insurance? Work Comp Health Medicare KanCare TriCare Liability Auto
4) What type of accident? Auto Sports Work Home

   If none of the above, (please specify)_____
5) What was the accident or injury date?_____
6) What was the accident or injury due to? Falling Lifting Twisting Crushing Auto Injury

   If none of the above (please specify) _____

C) Please give specific details of how this problem began:

_____

_____

_____

_____

_____

_____

_____ _____

Patient/Guardian Signature Date

Revised 03/27/2017