PROBLEM-RELATED INFORMATION

Patient Name: _____ **MRN:** _____

Provider: _____ **DOS:** _____

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

1) Was this an injury or did it just begin to bother you (onset of symptoms)? Circle below

   Accident/Injury Onset of Symptoms

2) Body Part: Right / Left / Both _____

3) What type of insurance? Work Comp/Health/Medicare/KanCare/Auto/Liability / _____

B) If this is an <u>onset of symptoms</u>, please skip to (C)

1) What type of accident? Work / Auto / Sports / School / Home

   If none of the above, (please specify): _____

2) What was the accident/injury date? _____

3) What was the accident or injury due to? Falling / Lifting / Twisting / Crushing / Auto

   If none of the above, (please specify): _____

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

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient/Guardian Signature Date

Revised 12/20/2022

(Scan: Pt Demographic/Info Sheet)