AdventHealth Ottawa

ACCIDENT AND INJURY REPORT

AdventHealth Ottawa Physician Practices and AdventHealth Express Care

PRIVATE/PUBLIC PROPERTY	**Patient Name:** **DOB:** **Date of Injury:** **Where did accident occur?** **State of Occurrence:** **Briefly describe events of accident or how injury occurred:** **Property Owners Insurance Information (if applicable), Claim # and Billing Address:**
AUTO	**Patient Name:** **DOB:** **Date of Injury:** **Where did accident occur?** **State of Occurrence:** **Briefly describe events of accident or how injury occurred:** **Auto Insurance Claim #, Billing Address and Phone number:**
WORK COMP **For Office Use:** **Verified by:** **Originating Office:** **Date:**	**Patient Name:** **DOB:** **Date of Injury:** **Where did accident occur?** **Briefly describe events of accident or how injury occurred:** **Did you notify Employer: ❑ YES ❑ NO** **Is today's care authorized? ❑ YES ❑ NO** **Employer Full Name** **Employer Contact/Supervisor Name and Phone #** **Employer Address:** **Work Comp Insurance Carrier Info:** **Work Comp Claim#** **Case Manager's Name** **Phone #** **Fax #** **Additional Info:**

In the event the insurance I provide denies payment or does not pay in full, I understand I am responsible for the remaining balance as explained in the AdventHealth Ottawa Health Physician Practices/AdventHealth Ottawa Express Care Financial Policy.

PATIENT SIGNATURE_____**Date:**_____