PATIENT NAME_____DATE_____

INJURY QUESTIONNAIRE

**** In order for Sportsmedicine Fairbanks to file your healthcare claims, we need your help****

The current trend with insurance carriers is to have the following information at the time the claim is filed. We appreciate your assistance in providing this information, so that we may complete the filing of your insurance claims.

A. **What body part(s) will you be seen for today (include left, right, or both)?**_____

B. **Briefly explain the symptoms you are currently having:**_____
_____

C. **Briefly describe where and how the injury (OR condition) occurred:** _____
_____

D. **Is this medical expense the result of an accident/injury?** _____YES _____NO
If YES, what kind of accident/injury?_____

E. **What is the date of injury/accident OR onset of your symptoms?**_____

F. **Is this medical expense the result of an automobile accident?** _____YES _____NO
Were you (CHECK ONE) _____the driver _____passenger _____pedestrian?
****We will bill your own insurance/policy, we will not bill another party's insurance/policy****
For injuries or conditions covered under the provisions of a Personal Injury Protection (PIP), Uninsured and/or Underinsured Motorist contract or policy, or other similar type coverage, complete the following:
Name of Policyholder:_____Policy #_____
Adjuster Name:_____Ins. Co. Name:_____
Ins. Co. Address:_____Ins. Co. Phone#_____

G. **Have you contacted an attorney?** _____YES _____NO
If YES please fill in the following information:
Attorney Name_____
Attorney Address:_____Attorney Phone #_____

H. **Injury or condition sustained while performing work required for your employment?** _____YES _____NO
Is this injury/condition covered by Workers' Compensation? _____YES _____NO
Employer Name_____
Employer Address_____Emp. Phone #_____

Are you Self-Employed?	_____YES	_____NO
Are you employed on Tribal Land?	_____YES	_____NO
Are you an owner or officer with company voting rights?	_____YES	_____NO
Are you an interstate employee?(do you cross state lines?)	_____YES	_____NO
Are you a Professional or Semi-Professional Athlete?	_____YES	_____NO

If the Department of Labor and Industries denied OR controverted your claim, please attach a copy of the actual denial OR controversion notice to this questionnaire so your insurance claim can be filed

If you decide in the future to contact an attorney or make a claim against any third party or Workers' Compensation carrier, you need to inform the Sportsmedicine Fairbanks Business Office of such action as soon as possible.

Signature of Patient and/or Subscriber:_____Date_____

Signature of Guarantor (if patient is a minor):_____Date_____