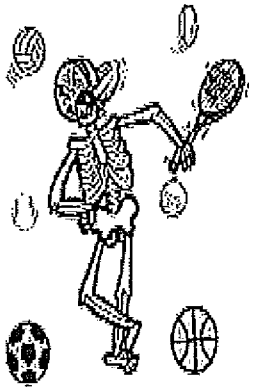

ORTHOPAEDIC SOLUTIONS & SPORTS MEDICINE CENTER, PA
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PATIENT ACCIDENT INFORMATION

Chart# _____ Patient _____ DOB _____

Date of injury _____ MVA _____ Home Work Other

Part of Body Injured _____

How did the accident happen? _____

Are you filing a liability claim against auto insurance, workers compensation or any other liability insurance other than your medical insurance? _____

If so, insurance name/agent_____

If you have hired an attorney, please give us name and phone # _____

Date of Onset of Pain _____ Location of pain_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment of these services, in the event that my medical insurance or other insurance benefits deny payments related to this accident. Also, I am authorizing use of this form to be sent to my medical/liability insurance to as additional information regarding the accident that would be requested Orthopaedic Solutions and Sports Medicine Center, PA

Patient Name Date

_____ _____