2860 Channing Way #100
Idaho Falls, Idaho 83404
208.535.4567
208.535.4569 fax

ACCIDENT/INJURY FORM

Patient's Name: ______________________________

Patient's SSN: ______________________________

Date of Accident/Injury: ______________________

PLEASE COMPLETE THE FOLLOWING INFORMATION SO THAT WE CAN PROMPTLY PROCESS YOUR CLAIM (*You may us the back of this form for your responses if necessary*)

1. Please describe the nature of the accident/injury:

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2. Where did the accident occur? ______________________________

3. Was this injury the result of a work-related accident? YES NO

If yes, please list Workers Comp. Insurance ______________________________

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4. Was this injury due to a motor vehicle accident? YES NO

If yes, please list the auto insurance and claim#______________________________

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5. Is someone else is liable for this accident, have you retained an attorney? YES NO

If yes, please provide your attorney's name, address, and telephone number:

____

THANK YOU FOR PROVIDING THIS INFORMATION.

____________________	____________________
Home Telephone Number	Cell or work phone number
____________________	____________________
Patient/Guarantor's Signature	Today's Date