# Patient Release & Injury Information

Complete ENTIRE FORM. Fill in or circle ALL ITEMS and write "N/A" where not applicable.

**Is your medical condition the result of a documented accident? Y* N**

*** IF ANSWER IS YES, THE REMAINDER OF THIS FORM MUST BE FULLY COMPLETED.****

**Signature** (Patient or Guardian) ______________________________ Date ______________

Name (If Other Than Patient) ______________________________ Relationship ______________

**Accident Information** (If Applicable)

Is there a Workers' Compensation claim? Y* N          Vehicle accident (no-fault) claim? Y* N

***** IF ANSWER TO EITHER IS YES, THE FOLLOWING MUST BE FULLY COMPLETED.*****

Injury Date ______________          Injury Location: City ______________ State ________

Employer's or Policyholder's Name ______________________________

Address ______________ City ______________ State ________ Zip ________

Insurance Company's Name ______________________________ Case/Claim # ______________

Address ______________ City ______________ State ________ Zip ________

Claim Representative's Name ______________________________ Tel. # ______________

Is the case still open for medical treatment? Y N

Are you working? Y N          If yes, are you on limited or restricted duty? Y N

If no, when was the last day you worked? ______________