Tulsa Spine & Specialty Hospital

ACCIDENT DISCLOSURE FORM

Section #1

Name _____
First Middle Last

Date of Onset / Accident / Injury _____

Is your condition due to an on the job injury? ☐ Yes ☐ No

Was the injury reported to your employer? ☐ Yes (if Yes, complete Section 2) ☐ No (If No, complete Section 3)

Is your condition due to any other type of injury? ☐ Yes ☐ No (If No, complete Section 3)

Section #2

Please provide details of the **On the Job Injury:** _____

_____

_____

When did the accident / injury occur? Date _____ Time _____ U.S. State _____

Was the injury reported to your employer? ☐ Yes ☐ No

Is the claim ☐ Open ☐ Settled ☐ In Litigation Settlement Date _____

Employer at time of injury _____ Phone _____

Work Comp Company _____ Phone _____

Attorney Name _____ Phone _____

If the claim has been denied or is in litigation, please provide a copy of health insurance cards**

Section #3

Where did the accident / injury occur? ☐ Home ☐ Work ☐ Sports ☐ Other _____

Please provide details of accident/injury _____

_____

Was someone else responsible for the injury? ☐ Yes ☐ No Who? _____

Is third party or liability insurance available for your medical treatment? ☐ Yes ☐ No

Do you intend to file a liability claim / lawsuit against any party who caused the injury? ☐ Yes ☐ No
(If Yes, please complete Section 4 below and provide health insurance card to be copied**)

Section #4

Name of Third Party / Liability Insurance _____ Phone _____

Policy # _____ Claim # _____

Please provide your automobile or homeowners information if applicable.

Name of Company _____ Phone _____

Policy # _____ Claim # _____

Is there medical payment available on this policy? ☐ Yes ☐ No

Do you intend to file a claim for medical payment on your policy? ☐ Yes ☐ No

Attorney Name _____ Phone _____

Signature _____ Date _____

** Copies of insurance cards are obtained because, in the event your claim is denied, we must file with your health insurance before timely filing provisions expire. Our office will communicate with you if this action must be taken.

Patient Identification / Label