

Midtown Sports Medicine
Eric S. Furie, M. D.

Patient Accident Details

Today's Date ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

**PLEASE PROVIDE A PICTURE ID AND YOUR INSURANCE CARD(S).
A PHOTOCOPY WILL BE MADE FOR YOUR MEDICAL RECORD.**

IS YOUR VISIT TODAY DUE TO AN ACCIDENT?

YES NO

If NO, you have finished this page.
If YES, please review and answer the following questions:

Is this visit for an injury related to work?

Yes No

Date of Accident ____/____/____

Has your Employer/Supervisor been notified?

Yes No

Date Last Worked ____/____/____

Supervisor's Name: _____ Phone: _____
If Not Working Now

Current Job Duties: _____

Workers' Compensation Insurance Company: _____

Insurer's Address: _____
Street City State Zip Code

Insurance Contact Person: _____ Phone: _____ Fax: _____

Is this visit for an injury due to an automobile accident or other accident not related to work? Yes No

Date of Accident ____/____/____ State where accident happened: _____

Insurance Company for this accident: _____

Insurance Address: _____
Street City State Zip Code

Insurance Contact Person: _____ Phone: _____ Fax: _____

Is there a lawyer involved in your case? Yes No

Lawyer's Name: _____ Phone: _____

Lawyer's Address: _____
Street City State Zip Code