Incident Questionnaire

ORTHOWASHINGTON

Patient Information

Patient Name:

Date of Birth:

Date of Injury: Date of Service:

Incident/Injury Information

Where Incident/Injury Occurred: ☐ Home ☐ School ☐ Work ☐ Auto ☐ Other:

Physical Area Affected:

Briefly describe the incident/injury or what caused the onset of symptoms. If no incident, please put "N/A".

Insurance Information

Primary Insurance

Subscriber:

Insurance Company:

Group Number: SSN or ID Number:

Secondary Insurance

Subscriber:

Insurance Company:

Group Number: SSN or ID Number:

Your insurance contract includes a subrogation provision. "Subrogation" means that if your insurance company makes any payments on your behalf for injuries caused by another party who may be liable for the injuries, your insurance company is entitled to recover those payments from the other party. As a condition of these payments, the subscriber agrees to cooperate with your insurance company in its efforts to recover the cost paid on behalf on the injured party.

I understand that if I or any of my dependents have been injured by another party, the benefits of my contract will be available to the injured person subject to the exclusions and limitations of the contract. I agree to cooperate with my insurance company in its subrogation and reimbursement rights as stated in the contract. My insurance company reserves the right to determine payment of attorney fees for recovery of its financial interests in the claim. I understand that I am not entitled to keep that portion of the settlement which represents reimbursement of the amount of my insurance company paid toward my medical benefits except as determined by applicable law.

I certify that the information on this form is true and accurate to the best of my knowledge.

Signature:

Print Name:

Date:

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