INJURY QUESTIONNAIRE

INFORMATION REQUESTED BY INSURANCE CARRIERS PRIOR TO PROCESSING CHARGES FOR DOCTOR'S OFFICE VISIT

Patient Name: ______________________________ Patient Age: __________________ D.O.B. ____________________

Insured Name: ____ ID #: _____________________ Date: ______________

1. A. Describe how the Injury occurred:

   ____

   ____

   ____

   B. Accident Location:

   ____

   C. Date of Accident: ___________________________ Time of Accident: ___________________________

2. A. Was your child on school property at the time of accident? Yes ______ No ______

   B. Was your child at a Day Care facility or a Babysitters residence? Yes ______ No ______
   Day Care ______ Babysitters _______

   C. Was you child injured on someone else's property? Yes ______ No ______

   D. Name, address, and phone number of property owner (School, day care, sitter, neighbor, relative, etc)

   Name: ____

   Address: ____

   Phone #: ____

3. A. Was the child in an auto accident? Yes _____ No _____ Passenger _____ Pedestrian _____

   B. Name of your auto insurance company:

   ____

   C. Auto Insurance policy number: _________________________ Phone: __________________________

4. If none of the above apply, please explain (child fell at home, etc):

____

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____

Parent/ Legal Guardian Signature: ____