Clay Center Family Physicians
PO Box 520 / 609 Liberty Street
Clay Center, KS 67432
Phone (785) 632-2181 Fax (785) 632-2309

INJURY REPORT

TODAY'S DATE: _____

PATIENT'S NAME: _____BIRTHDATE: _____

ADDRESS: _____

_____

PHONE: _____ CELL: _____ WORK: _____

DATE OF ACCIDENT/ INJURY: _____

COMPLETE ADDRESS OF ACCIDENT/INJURY: _____

_____

DETAILED DESCRIPTION OF ACCIDENT/INJURY : _____

_____

_____

Was accident/injury **AUTO related?** **Y** ◯ **N** ◯
Will this be covered by **AUTO ins?** **Y** ◯ **N** ◯
IF YES, PLEASE LIST AUTO INSURANCE INFO:

POLICY INFORMATION: _____

ADDRESS/PHONE: _____

_____

_____

Was accident/injury WORK related? **Y** ◯ **N** ◯
Will this be covered by **WORK COMP?** **Y** ◯ **N** ◯
IF YES, PLEASE LIST WORK INFO:

EMPLOYER INFORMATION:_____

ADDRESS/PHONE: _____

_____

_____

DO YOU REQUIRE AN ADDITIONAL CLAIM FORM FOR ACCIDENT COVERAGE (AFLAC*)* yes ◯ no ◯
This will be mailed directly to you so you can file a claim.

PATIENT SIGNATURE: _____
(other-party signature relationship _____)

PROVIDER INITIAL: _____