

CJHS - WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENT - PLEASE PRINT LEGIBLY

LAST NAME: _____ FIRST NAME: _____ M.I.: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ SS#: _____ HOME PHONE: _____ WORK PHONE: _____

Do not call me at work

SEX _____ MARITAL STATUS _____ CELL PHONE: _____ OCCUPATION: _____

EMPLOYER: _____ EMAIL ADDRESS: _____

EMPLOYER ADDRESS: _____ EMPLOYER'S PHONE #: _____

HOW AND WHERE DID ACCIDENT OCCUR? _____

DATE OF INJURY OR ACCIDENT: _____

DESCRIPTION OF PROBLEM: _____

FAMILY PHYSICIAN NAME & ADDRESS: _____

WHO REFERRED YOU TO US? _____ ADDRESS: _____

DO YOU HAVE? (Please check) DIABETES _____ HYPERTENSION _____ HEART DIS _____ CANCER _____ SMOKE _____ HEPATITIS _____ HIV+ _____

MEDICATIONS YOU'RE TAKING: _____ HAND INJURED: RT _____ LT _____

KNOWN ALLERGIES: _____ CHECK ONE: RIGHT HANDED _____
LEFT HANDED _____

INSURANCE COMPANY COVERING INJURIES: _____

INSURANCE COMPANY'S ADDRESS _____

CLAIM #: _____ ADJUSTOR: _____ TELEPHONE #: _____

SECONDARY INSURANCE: _____ ID #: _____

INSURED'S NAME: _____ RELATIONSHIP TO PT.: _____ BIRTHDATE: _____

I hereby authorize payment from the insurance company to be sent directly to Central Jersey Hand Surgery for any service rendered to me by the group. I also authorize the release of medical information to my insurance company in order for Central Jersey Hand Surgery to complete necessary insurance forms. **You** are personally responsible for the payment of all bills, if your claim is denied (for any reason). You are also responsible for any co-insurance amounts, non-covered charges and any balance remaining after insurance payment to our office.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Doctors Pess, Decker, Gabuzda, Atik and Fedorcik will attempt to improve the patient over their present status, but cannot return the patient to normal status.

SIGNATURE: _____

DATE: _____

