

Orthopaedic Associates of North Texas

Patient Injury or Illness Information

Patient Name: _____ Date: _____

What is the reason for your visit today? _____

Is your visit today related to any of the following reasons? Please answer YES or NO in the blank below:

Motor Vehicle Accident? _____ Work Related? _____ Are you a Nursing Home Patient? _____

Have we treated you for this condition before? Yes _____ No _____ If Yes, when? _____

Are you here today for a new problem? Yes _____ No _____

Which side of the body? Left: _____ Right: _____ Both: _____

Date of Injury or Start Date of Problem: _____

If you injured yourself:

Describe how and what happened: _____

Where did your accident occur? _____ City: _____ State: _____

*Do you have attorney representation, or do you plan to get one? Yes _____ No _____

*Are there other parties that will be named as being responsible for payment of your account due to your injuries? Yes _____ No _____

If you neglect to advise Orthopaedic Associates of North Texas before your first appointment that this is work related, the below statement applies:

I understand and agree that I am responsible for all charges for services rendered in the event that my claim for Worker's Compensation benefits is denied.

Signature of Patient/Responsible Party

Date