INTEGRIS

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Injury Information Questionnaire

Patient Name:___________________________________

Account#_____________________________________

1. **Have you or a family member been hurt in an accident?** ❑ **Yes** ❑ **No**
   If yes, name of injured person:____
   Relationship:____

2. **What was the date of the accident? Date:**_______________________

3. **Did the accident happen while you (or your family member) were working?** ❑ **Yes** ❑ **No**
   If yes, patient's employer: ____
   Workers Compensation Carrier: _____________________________________

4. **Did the accident involve a car or other type of vehicle?** ❑ **Yes** ❑ **No**
   If no, please explain what type of accident: ____

5. **Is there insurance for the vehicle(s) involved in the accident, or the property where the accident happened?**
   ❑ **Don't Know** ❑ **Yes** ❑ **No**
   If you answered yes, please answer the following information about the insurance:
   Insurance Company: ____
   Address & Phone: ____
   Policy/Claim Number: ___________________________________
   Assigned Claim Handler: ____

   a. **List the City and the State where the accident happened:** ____________________________________

   b. **If a police department responded, list the Dept/Case Number:** ___________________________

6. **Did another person cause the accident?** ❑ **Yes** ❑ **No**
   Name and Address of responsible party: ____
   Please list any insurance information for the person that caused the accident:
   Insurance Company: ___________________________________
   Address & Phone: ____
   Policy/Claim Number: ___________________________________
   Assigned Claim Handler: ____

7. **Did you or your family member hire an attorney?** ❑ **Yes** ❑ **No**
   If yes, Attorney Name: ____
   Address & Phone Number: ____
   ____

8. **Has your (or your family members) claim settled?** ❑ **Yes** ❑ **No**

. . . .

By signing below, you agree that the information in the form is true and accurate.

___________________________	___________________________	___________________________
Signature	Print Name	Date
___________________________	___________________________	___________________________
Home Phone Number	Email Address	Other Phone Number

****If an accident report is available, please attach a copy to this form and specify which agency filled out the report. Return in the envelope provided. If you have any questions, please contact the business office at 405-252-8578**