QUEENSRIDGE SURGERY CENTER
ACCIDENT QUESTIONAIRE

Please complete the requested information for billing. Incorrect billing information will result in full payment responsibility from the patient/ patient representative.

1. Is your procedure because you have an injury from an accident? □ **No**-sign and return to front desk **Signature** _____ □ Yes-continue to #2

2. Is your procedure because you had a □ **car accident**-if yes, go **to Section 1**

   □ **work related**-if yes, go to **Section 2**

   □ **other type of accident**-go to **Section 3**

SECTION 1: CAR ACCIDENT

Date of accident: _____

1. Have you notified your insurance company?

   □ Yes-Name of insurance company _____ Phone # _____

   □ No-explain _____

2. Have you contacted a lawyer/attorney? □ No

   □Yes-Name and contact number:_____
   Is this an Attorney Lien? □ No □Yes Is this another lien? If so, with what company and contact number _____

SECTION 2: WORK RELATED

1. Have you notified your employer? □ No □ Yes Claim # _____ Date of Injury _____

2. Employer Name _____

   Address _____ Phone # _____

   Are you currently working? □ Yes □ No-last day worked _____

3. Worker's Comp (MCO) Carrier and Adjuster Name _____
   Phone # _____

4. Have you completed an employer's C-3 form? □ Yes □ No

5. Have you completed a Dr's C-4 form? □ Yes □ No

6. Is there anything else we should know about this injury or worker's comp claim? If so, please explain _____

SECTION 3: OTHER INJURY

Date of injury _____

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1. Type of injury-explain_____
2. Is there insurance coverage for this injury-if so, provide name of company, phone #, claim #
   _____
3. Has a lawyer/attorney been contacted for this injury-if so, provide name of attorney & phone #

   _____
4. Has a Med Pay or Attorney Lien been signed-if so, provide contact name and number_____