Grand Centre
5400 N. Grand, Suite 500
Oklahoma City, OK 73112

Northwest PHYSICAL THERAPY CLINIC

Silver Leaf Business Park
609 S. Kelly, Suite L-4
Edmond, OK 73003

Accidental Injury Questionnaire

Is this Physical Therapy care the result of an accidental injury?

☐ No-Please sign if your treating condition is **NOT** the cause of an accident:

Patient/Guardian Signature: _____ **Date:** _____

☐ Yes (Please complete the following as it applies to your accident)

Motor Vehicle Accident & 3rd Party:

Date of accident: _____ **Time:** _____ **Location:** _____
The patient was a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other (Explain): _____
The vehicle was a: ☐ Automobile ☐ Motorcycle ☐ Other (Explain): _____
Who was at-fault: ☐ Patient ☐ Other (Name): _____

Insurance of **at-fault** person: _____ Address: _____
ID/Claim #: _____ **Group #:** _____
Agents Name: _____ Phone: (___) ____-_____

Do you carry Personal Injury Protection? ☐ No ☐ Yes Limit $ _____
Do you carry Uninsured Motorist Insurance? ☐ No ☐ Yes Limit $ _____
Does your vehicle insurance include medical? ☐ No ☐ Yes Limit $ _____

Patient Attorney: _____ Phone: (___) ____-_____
At-Fault Person Attorney: _____Phone: (___) ____-_____

Workers Compensation:

Date of accident: _____ **Time:** _____ **Location:** _____

Name of employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____

Name of Employers Workers Compensation Carrier: _____
Address: _____ City: _____ State: _____ Zip: _____
Case Manager Name: _____ Phone: (___) ____-_____ Ext: _____
Claim/Case #: _____

Visits Requested: _____ #Authorized: _____ Person Authorized: _____
Effective Date: _____ Expiration Date: _____
Verified by: _____Date: _____

I certify that the above information is correct & understand that I am obligated to provide this information according to the provisions of the plan. Failure to provide complete & accurate information will result in a delay in the processing of my benefits.

Patient/Guardian Signature: _____Date: _____