

Champlain Valley Open MRI

Accredited by the American College of Radiology

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Accident-related Patient Questionnaire

Today's visit is not accident related. Patient signature _____ Date: _____

If accident related:

Date of accident: _____ City: _____ State: _____

Is an attorney involved with this case? _____

Attorney's Name: _____ Address: _____

City: _____ St: _____ Zip: _____

Phone: (_____) _____ - _____

Describe the nature of the accident:

Please identify the insurance company* to be billed for your injury:

Auto accident:

Insurance company: _____

Phone: (_____) _____ - _____

Policyholder: _____

Claim number: _____

Policy number: _____

Work Comp:

Insurance company: _____

Phone: (_____) _____ - _____

Policyholder: _____

Claim number: _____

Policy number: _____

Sports injury:

Insurance company: _____

Phone: (_____) _____ - _____

Policyholder: _____

Claim number: _____

Injury at school:

School insurance company: _____

Phone: (_____) _____ - _____

Name of the school: _____

Claim number: _____

Other Injury: _____

Insurance company: _____

Phone: (_____) _____ - _____

Policyholder: _____

Claim number: _____

Policy number: _____

Patient signature: _____ Date: _____

Thank you for taking the extra time to provide this information.

***You will also be asked to supply personal insurance information that may be used if the insurance listed above denies the claim.**