Center for Hand Surgery Inc **Michelle R. Ritter**, Orthopaedic Hand Surgeon

INJURY DETAILS

PRINT NAME_____ DOB____/____/_____
Last (required) First (required) mm/dd/yyyy (required)

1. Is this work related? ☐ Y ☐ N Have you reported it to your employer? ☐ Y ☐ N

If reported, Name and phone number of Employer and Adjuster (if known) responsible for payment.

_____

Please understand that your health insurance will not cover a work related problem.

2. Is this an auto accident? ☐ Y ☐ N ***We do not bill your auto insurance. Pay at your appointment.***
3. Other injury? ☐ Y ☐ N Describe _____
4. When did the injury occur? Date_____ Time_____ Approx Date if unsure _____
5. What is the name of the place_____and address where it occurred?

_____

6. How did it happen? Be specific. _____

_____

_____

_____

_____

_____

_____

Where is your injury? Check all that apply.

Hand_____ ☐ R ☐ L **Wrist**_____ ☐ R ☐ L **Arm**_____ ☐ R ☐ L **Elbow**_____ ☐ R ☐ L

Finger(s) **Index** ☐ R ☐ L **Middle** ☐ R ☐ L **Ring** ☐ R ☐ L **Little** ☐ R ☐ L **Thumb** ☐ R ☐ L

7. Do you have a lawyer or do you plan to have a lawyer? If yes, give name and phone number.

Attorney:_____Phone:_____

Address and /or City: _____

IT IS OUR POLICY THAT ATTORNEYS MAY NOT ACCOMPANY YOU INTO THE EXAM ROOM.
Nurse case managers are permitted.

Please sign and date _____/_____/_____
(REQUIRED) **mm** **dd** **yyyy**

 Revised 2018