Back & Neck Clinic
OF NEW PRAGUE

Personal Injury

Patient Name _____ Today's Date _____

Date of Birth _____ Phone Number _____

Address _____

Date of Accident _____ Time of Accident _____ AM or PM

1. Where did the accident occur? _____

2. Describe how the accident happened in detail (very important) _____

_____

_____

3. What injuries did you sustain? _____

4. Did you have any of these symptoms prior to the accident? Yes or No

If yes, what symptoms did you have and when did you have them? _____

_____

5. Have you had any other medical care for this injury? Yes or No

If yes, what is the name and address of the facility? _____

_____

6. If you are represented by an attorney, please give name and phone number _____

_____

Insurance Information

Insured's Name _____

Claim # _____ Claim Adjuster's Name _____

Insurance Company _____ Policy # _____

Insurance Company Address _____

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Authorization for Disclosure of Medical Information

I hereby authorize the use and/or disclosure of my health information related to my date of injury on _____, to the requestor's claims representatives and/or agents. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the information may be further disclosed and may no longer be protected by federal privacy regulations. I further authorize The Back and Neck of New Prague to disclosure information related to the claim even if such information was created or already existed prior to the date of this authorization.

Today's Date _____

Print Patient's Name _____

Signature of Patient _____

(If patient is a minor, we need the guardian's signature)

(952) 758-5135
201 E Main St
New Prague, MN 56071