ATTENDING PHYSICIAN'S REPORT

DATE	CLAIMANT	DATE OF ACCIDENT	FILE NUMBER

TO:

1. PATIENT'S NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)

5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS AND CURRENT CONDITIONS

7. WHEN DID SYMPTOMS FIRST APPEAR?

DATE:

8. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?

DATE:

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF "YES" STATE WHEN AND DESCRIBE

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT?

YES ☐ NO ☐ IF "NO" EXPLAIN

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

12. WILL INJURY RESULT IN A PERMANENT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ IF "YES" DESCRIBE

13. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: THROUGH:

14. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON

DATE:

15. IF PATIENT WAS HOSPITALIZED, NAME OF HOSPITAL

PERIOD OF HOSPITALIZATION

FROM TO

16. REPORT OF SERVICES AND ATTACH ITEMIZED BILL

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CHARGES
			$
			$
			$
			$
		TOTAL CHARGE TO DATE	$

17. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES ☐ NO ☐

DATE PHYSICIAN'S NAME (PRINT) PHYSICIAN'S SIGNATURE

IRS/TIN IDENTIFICATION NO.

NO. STREET CITY OR TOWN

STATE ZIP CODE

WILLFULLY FALSIFYING FACTS ON THIS STATEMENT MAY RESULT IN DENIAL OF YOUR CLAIM AND OR CRIMINAL PROSECUTION FOR FRAUD