SCOTT Orthopedic CENTER

INJURY FORM

Patient Name: _____

Insured Name: _____

Is your visit today related to an accident or injury? Yes No (If no skip the rest of the form)

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When did the accident or injury happen? Date:_____ Time (Approximately): _____

Where did it happen? Home Work Auto Accident School Other:_____

What body part is injured? _____

What happened: _____

_____

_____

Did you go to the Emergency Room / Urgent Care? Yes No

Where: _____Date:_____

Did your Primacy Care Physician refer you to the walk in clinic? Yes No

Primary Care Physician Name: _____

The above information is true to the best of my knowledge

Signature: _____Date: _____