ACCIDENT QUESTIONNAIRE FORM

Is your chief complaint the result of an accidental injury? **YES** ☐ **NO** ☐

IF NO, skip the next section and sign at bottom.

IF YES, date of injury____________________ Where did it occur?______________________________

Describe how accident occurred ____

____

HAVE YOU FILED A CLAIM REGARDING THIS INJURY WITH ANY OF THE FOLLOWING ?

Worker's Compensation **YES** ☐ **NO** ☐

Motor Vehicle Insurance **YES** ☐ **NO** ☐

Homeowner's **YES** ☐ **NO** ☐

Do you plan on filing a claim in the future? **YES** ☐ **NO** ☐

Have you sought the advice of an attorney? **YES** ☐ **NO** ☐

If yes, give attorney's name and phone number____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of benefits be made on behalf of OneCore Health Open MRI for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply (if applicable).

I authorize any holder of medical or other information about me to release to the Social Security Administration and health care financing administration or it's intermediaries or carriers for any information needed for this or any related Medicare / other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefits be paid to the party who accepts assignment.

I HAVE READ ALL OF THE ABOVE AND IT IS TRUE AND CORRECT.

Patient Signature____ Date_____________

Print Name____

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