RM | ROBERT MORIN MD
PLASTIC SURGEON

ACCIDENT CASE FORM

Date of Accident _____

Location of Accident: [ ] Work [ ] Home [ ] Auto [ ] School [ ] Other

If other, please explain in detail: _____

If work related, please request a workers' compensation worksheet from the receptionist. If auto related, please request an auto accident worksheet from the receptionist.

Attorney Information

Law Firm: _____

Address: _____

Name of Attorney: _____

Phone # _____ Fax # _____

Email address: _____

Does our office have your consent to discuss treatment and financial details with your attorney and his/her representatives? [ ] Yes [ ] No X_____
Initial here

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WORKERS COMPENSATION CASE HISTORY

Patient Name: _____ Account # : _____

Social Security #:_____ Date of Injury: _____

Employer Name / Address:

_____

_____

_____

_____

Employer Phone Number:

_____

Workers Compensation Insurance Company Name / Address:

_____

_____

_____

Claim #:

_____

Adjustor Name / Phone Number:

_____