



INITIAL REPORT OF INJURY

PATIENT NAME: _____ DOB: _____
(Last) (First) (MI)

SEX: MALE or FEMALE SS#: _____ PHONE #: _____
(Circle one)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

COMPANY NAME: _____ COMPANY CONTACT: _____
(Manager or supervisor)

COMPANY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

COMPANY PHONE#: _____

COMPANY INSURANCE CARRIER: _____ CARRIER PHONE#: _____

CARRIER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CARRIER CONTACT: _____ POLICY NUMBER: _____

BILL TO COMPANY: PAY ON DAY OF SERVICE:

Work Comp Self Pay: Employee Responsibility Employer Responsibility

DATE AND TIME OF INJURY: _____

WHERE IS YOUR INJURY? (I.e. back, right knee, left foot): _____

HOW DID YOU GET HURT? _____

WHAT SYMPTOMS ARE YOU EXPERIENCING? _____

I, the undersigned do hereby authorize FIRST MED Urgent Care to release this report of injury prepared today.

To: _____ FIRST MED Witness Signature _____
Name of Company

_____ Date _____
Patient Signature

OFFICE USE ONLY

Date and Time of Authorization: _____

Name of Authorizing Person: _____

Phone #: _____ Initials: _____

OFFICE USE ONLY

Drug Screen: Yes No

Name of Authorizing Person _____

Phone #: _____ Initials: _____