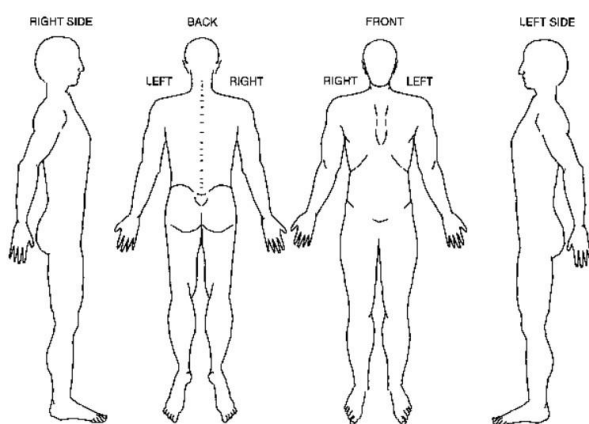


Injury Intake Form

All fields must be completed. If the information is not yet available, write "unknown," and/or notate other details, as needed.

| Patient Information | | | |
|-----------------------------|---------------------|--------------------------------------|-------------------------------|
| Injured Body Part(s): _____ | Date: _____ | | |
| Last Name: _____ | First Name: _____ | Middle Initial: _____ | |
| Date of Birth: _____ | Phone Number: _____ | Sex: <input type="checkbox"/> Female | <input type="checkbox"/> Male |
| Mailing Address: _____ | | | |
| Email: _____ | | Employer: _____ | |

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information commits insurance fraud, punishable as provided in sections 817.234, F.S. and 440.105(7), F.S. Within 7 days after actual knowledge of injury or death, the employer shall report such injury or death to its carrier, in a format prescribed by the department, and shall provide a copy of such report to the employee or the employee's estate as stated in 440.185(2), F.S.

| Injury Information | |
|--|-----------------------|
| Social Security Number (SSN) : _____ - _____ - _____ | |
| Have you reported this injury to your employer? <input type="checkbox"/> NO <input type="checkbox"/> YES | Date of Injury: _____ |
| Describe the accident in detail (include where and how it happened) : | |
| | |
| Mark the injured areas / body part(s) with an "X." Please be specific and identify right or left. | |
|  | |
| Have you been treated for this injury by another facility (e.g. ER, urgent care, primary care, etc.)? <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| If yes, list the facility: _____ Phone Number: _____ | |
| Have you injured this body part or had similar problem(s) in the past? <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| If yes, explain the history of previous injury: | |
| | |
| Was the past problem related to work? <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| | |
| List any previous surgeries: | |
| | |
| Any previous Workers' Compensation claims or Motor Vehicle Collision claims? <input type="checkbox"/> NO <input type="checkbox"/> YES | |
| If yes, provide details of previous claim: | |
| | |
| List any secondary jobs / work, if applicable: | |
| | |

I confirm that the information provided on this form is true and accurate to the best of my knowledge at the time of service.

Patient Signature: _____ Date: _____

Medical Provider Signature: _____ Date: _____