

**INDUSTRIAL QUESTIONNAIRE**

Please fill out form COMPLETELY using your LEGAL name. Do not leave any blanks.

DATE: \_\_\_/\_\_\_/\_\_\_ TO SEE DR. \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_

PATIENT'S LEGAL NAME: Mr./Mrs./Ms./Miss \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: Male \_\_\_ Female \_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS: M \_\_\_ S \_\_\_ W \_\_\_ D \_\_\_

HOW DID YOU HEAR ABOUT THIS OFFICE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**EMERGENCY NOTIFICATION**

NAME OF FAMILY MEMBER, PARENT OR GUARDIAN: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_ EXTENSION: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**INSURANCE INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_ CLAIM NO.: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ADJUSTER'S PHONE NO: \_\_\_\_\_ EXTENSION: \_\_\_\_\_ FAX NO.: \_\_\_\_\_

**OTHER INFORMATION**

FOR WHAT PROBLEM (PART AND SIDE OF BODY) ARE YOU BEING SEEN: \_\_\_\_\_

DID YOU HAVE AN ACCIDENT OR INJURY: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_ PLACE: \_\_\_\_\_

IF YES, WHAT TYPE OR KIND: \_\_\_ AUTO ACCIDENT \_\_\_ SPORTS \_\_\_ FALL \_\_\_ OTHER PLEASE EXPLAIN: \_\_\_\_\_

IF YOU HAD AN ACCIDENT OR INJURY, IS THERE A THIRD PARTY INSURER INVOLVED: \_\_\_\_\_ YES \_\_\_\_\_ NO

PLEASE EXPLAIN: \_\_\_\_\_

HAS A DOCTOR TREATED OR EXAMINED YOU FOR THIS PROBLEM: \_\_\_ YES \_\_\_ NO

IF YES, DOCTOR'S FULL NAME: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_

IS THIS AN ON-THE-JOB ACCIDENT: \_\_\_ YES \_\_\_ NO EMPLOYER AT TIME OF ACCIDENT: \_\_\_\_\_

WAS THERE ANY TIME LOST FROM WORK? \_\_\_ YES \_\_\_ NO FROM: \_\_\_\_\_ TO: \_\_\_\_\_

**AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I hereby authorize payment of benefits directly to EMPIRE SPECIALITY ORTHOPEDIC CENTER / Dr. THOMAS DONALDSON of the surgical and/or medical benefits, if any, otherwise payable to me for their service.

I understand that I am financially responsible for any charges not covered by insurance benefits and I am also responsible for any collection or legal costs incurred should such costs be necessary because of no-payment.

I hereby authorize the release of any medical or other information necessary for the processing of insurance benefits or medical and/or surgical services rendered.

I hereby authorize treatment by Dr. Thomas Donaldson and staff.

\_\_\_\_\_  
Signature of Patient\_\_\_\_\_  
Date