LAS VEGAS NEUROSURGERY, ORTHOPAEDICS & REHABILITATION, LLP.

SURGICAL ADVISORS, INC.

ACCIDENT INJURY QUESTIONNAIRE

Patient Name: ____

SSN/ID #: ____

1). When did the illness/injury occur? Time of day: ______ ( ) AM ( ) PM

2). Where did the illness/injury occur? ______________________________

3). How did the illness/injury occur? ________________________________

____

4). Do you believe your illness/injury was work related? ( ) YES ( ) NO

5). Did you report the condition to anyone? ( ) YES ( ) NO

If YES, to whom? _________________________ Date: ___________

6). Do you expect to receive or have you been provided with Workers Compensation

Benefits? ( ) YES ( ) NO

(Note: Workers Compensation is not the same as State Disability)

7). Is treatment for an auto accident? ( ) YES ( ) NO

If YES, what was the date of the accident? _________________________

How did the accident happen? ___________________________________

Where did the accident occur? ___________________________________

Patient Signature: ______________________________ Date: ____________

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