Elmwood Orthopedic Rehab Center, Inc.

193 Elmwood Avenue
Providence, RI 02907
Tele: 401.459.4000 Fax: 401.459.4005

General Liability Intake Form

Intake Date: ____________________ Interviewer: ________________________

BASIC PATIENT INFORMATION

Circle One: **General Liability** **MBTA** **Slip & Fall**

Date of Injury: ________________________ Gender: **Male / Female** (circle one)

First Name: ____________________________ Last Name: _____________________________

Address: ____

City: _____________________________ State: ____________ Zip: ____________________

Home Phone: __________________________ Work Phone: ____________________________

Cell Phone/Pager: ________________________ Date of Birth: ___________________________

Social Security No: ______________________ License: _________________________________

Marital Status: **Single** **Married** **Divorce**

EMPLOYMENT INFORMATION

Employer Name: ____

Occupation: __________________________ Tele #: ______________________________

Are you missing time from work? **YES** **NO** (circle one)

How long? ____

ATTORNEY INFORMATION

Name: ____

Address: ____

Telephone #: ______________________________ Contact: ____________________________

HEALTH INSURANCE INFORMATON

Do you have Health Insurance? **YES** **NO** (circle one)

Name of Health Insurance Carrier: ____

Subscriber: ______________________________ Card No: ___________________________________

Group No: _______________________________ Exp. Date: _________________________________

GENERAL LIABILITY/MBTA INFORMATION

Owner of Property: ____

Location of Property: ____

____

MBTA bus No: ______________________________ Route: __________________________________

Insurance Carrier Name: ____

Claim No: _____________________________ Adjustor: ____________________________________

INJURY INFORMATION

Were Police at the scene? **YES** **NO** (circle one)

Was patient removed from the scene by ambulance? **YES** **NO** (circle one)

Was patient taken to Hospital? **YES** **NO** (circle one)

Name of Hospital: ____________________________________ Date of visit: ____________________

What are your major complaints: ____

____

DESCRIPTION OF ACCIDENT

Brief description of accident, please write below:

____

____

____

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient's Name: ____ Date: _______________________

Patients Signature: _______________________________________