

SCOTT ORTHOPEDIC CENTER INJURY FORM

**NOTE: IF YOUR VISIT TODAY IS NOT DUE TO AN ACCIDENT OR INJURY, DON'T COMPLETE THIS FORM!**

PATIENT NAME \_\_\_\_\_

INSURED NAME (if different) \_\_\_\_\_

IS YOUR VISIT TODAY RELATED TO AN ACCIDENT OR INJURY?      YES                      NO

**IF NO, SKIP THE REST  
OF THE FORM !!**

WHEN DID THE ACCIDENT OR INJURY HAPPEN?

\_\_\_\_\_  
MONTH                      DAY                      YEAR

\_\_\_\_\_  
TIME OF DAY (APPROXIMATELY)

WHERE DID IT HAPPEN?      YOUR HOME      AT WORK      AUTO ACCIDENT      AT SCHOOL

OTHER: \_\_\_\_\_

WHAT BODY PART IS INJURED?      RIGHT      LEFT      \_\_\_\_\_

WHAT HAPPENED?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_