

SOMERSET ORTHOPAEDICS, INC.
AUTOMOBILE INJURY MEDICAL REPORT CONFIRMATION

Name of Patient: _____

Date of Birth: _____ Social Security # _____

Date of Accident: _____ Reported to Insurance: Yes or No

What is the nature of injury: _____

Are you disabled as a result of this injury? _____

If yes, when did disability begin (first day you missed work) _____

Name of Auto Insurer: _____

Address: _____

Claim Number: _____

Adjustor Name: _____

Phone Number: _____ Fax Number: _____

I reported the injury to my auto insurer and I understand that if the claim is not paid that I am responsible for the payment of services. I authorize submission of information pertinent to this claim to be sent to the parties responsible for payment of claims and/or involved in the treatment of this injury.

Signature: _____ Date: _____