COLUMBUS ORTHOPEDIC & SPORTS MEDICINE CLINIC
Richard R. Cimpl, M.D. · Edward V. Fehringer, M.D. · Michael H. McGuire, M.D. ·
Dustin L. Volkmer, M.D. · Brandon L. Borer, DPM · Kelli Thomazin, PA-C
4508 38th St., Suite 133 · Columbus, NE 68601

Account # ________________

INJURY REPORT

Today's date

PATIENT'S NAME: ______________________________________ **DATE OF INJURY:** __________________

PLEASE DESCRIBE THE INJURY INCLUDING WHAT YOU WERE DOING WHEN INJURY OCCURRED AND WHERE INJURY HAPPENEED (I.E. home, work, school, etc.)

☐ **Home** ☐ **School** ☐ **Work**

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WORK RELATED INJURY - Please write your employer's full name, address, phone #, and fax#:

Employer ____

Address ____**City** _________________ **State** ____ **Zip** _____________

Phone # __________________________ **Fax#** ____________________________

IF MOTOR VEHICLE ACCIDENT PLEASE ASK FRONT OFFICE FOR ADDITIONAL FORM AND MAKE SURE YOU HAVE ALL PERTINENT INFORMATION AT YOUR APPOINTMENT. (Such as an accident report)

Auto-accident ☐ **Driver** ☐ **Passenger** ☐ **Front** ☐ **Back – Drivers side** ☐ **Back – Passengers side**

Please write responsible party's name, address & phone:

Name ____

Address ____**City** _________________ **State** ____ **Zip** _____________

Phone # __________________________

☐ **Personal Attorney**

Name: ____

Address ____**City** _________________ **State** ____ **Zip** ___________

Phone: ______________________________

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AUTOMOBILE ACCIDENT INFORMATION

PATIENT'S NAME: ______________________________ **TODAY'S DATE:** ____________________

PATIENT'S BIRTH DATE: ________________________ **DATE OF INJURY:**___________________

YOUR AUTOMOBILE INSURANCE INFORMATION

NAME OF INSURANCE AGENT: ____

NAME OF INSURANCE AGENCY: ____

ADDRESS OF INSURANCE AGENCY: ____

TELEPHONE NUMBER OF AGENT: ____

NAME OF INSURANCE COMPANY: ____

NAME OF POLICY OWNER: ____

INSURANCE POLICY NUMBER: ____

OTHER PARTY AUTOMOBIILE INSURANCE INFORMATION

NAME OF INSURANCE AGENT: ____

NAME OF INSURANCE AGENCY: ____

ADDRESS OF INSURANCE AGENCY: ____

TELEPHONE NUMBER OF AGENT: ____

NAME OF INSURANCE COMPANY: ____

NAME OF POLICY OWNER: ____

INSURANCE POLICY NUMBER: ____