iMsk & Spine Group
INTEGRATED MUSCULOSKELETAL, SPINE, AND REHAB MEDICINE

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Hicksville Office
111 W. Old Country Road, Suite 101
Hicksville, NY 11801
p 516.934.0380
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Patient Accident Information

Patient information

Last Name: Apellidos: _____ First Name: Nombre: _____ Date of birth: Fecha de nacimiento: _____

Injury details

Date of injury: Fecha del Accidente: _____

Did you report the accident? Usted reporto el accidente? ☐ yes si ☐ no no

Which part(s) of your body became injured? Qué parte de su cuerpo quedo herido?

Neck el Cuello	Lower back Espalda Baja	Shoulder el Hombro	Elbow el Codo	Wrist/Hand la muñeca/la mano	Hip la cadera	Knee la Rodilla	Ankle/Foot el Tobillo/el Pie
☐	☐	☐ left izquierda ☐ right derecha	☐ left izquierda ☐ right derecha	☐ left izquierda ☐ right derecha	☐ left izquierda ☐ right derecha	☐ left izquierda ☐ right derecha	☐ left izquierda ☐ right derecha

Other: Otro: _____

Explain how the injury happened and where: Explicar cómo ocurrió la lesión y donde:

Did you require hospitilization? Requirio hospitalizacion? ☐ no no ☐ yes; si; Hospital name: Nombre del hospital: _____

Have you seen any other doctor for this injury? Ha visto a algun otro medico por esta lesion? ☐ no no ☐ yes; si; Doctor's name: Nombre del medico: _____

History of prior injury or accidents

Date: Fecha: _____ ☐ NF ☐ WC ☐ Other Otro Area of body injured: Area del cuerpo lesionada: _____

Date: Fecha: _____ ☐ NF ☐ WC ☐ Other Otro Area of body injured: Area del cuerpo lesionada: _____

Date: Fecha: _____ ☐ NF ☐ WC ☐ Other Otro Area of body injured: Area del cuerpo lesionada: _____

Work Status

Are you currently working? Usted esta trabajando ahora? ☐ yes si ☐ no no

Did you miss any work because of the injury? Usted dejo de trabajar por e accidente? ☐ no no ☐ yes yes First date of missed work: Primer dia que dejo de trabajar: _____

Employer: Empleador: _____ Occupation: Ocupacion: _____

Address: Direccion: _____ City: Ciudad: _____ State: Estado: _____ Zip: Zip: _____ Phone: Telefono: _____

Guarantee Agreement

Individual responsibility for non-covered services: In the event that I fail to provide The Pain Group, PC, with valid No Fault – Workers Compensation information or if it is determined by the Insurance Carrier that the condition is not a result of the accident as stated above, I agree to pay for all medical services rendered to me by The Pain Group, PC.

_____ _____

Signature of Patient or Authorized Representative Date