



ASHLEY VALLEY FOOT AND ANKLE, INC.

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Injury Questionnaire

The following questions should be addressed for each office visit that may be accident or injury related.

1. Date of accident _____/_____/_____ **(month/day/4 digit year)**

2. Where did the accident occur?

At home – Patient’s own residence

Work, place of employment

Commercial business location

Other public building _____

Recreation area, someone else’s home, school, church, other _____

3. How did the accident occur?

4. Did the accident occur in, on, or around an automobile? YES NO

If YES, complete the following:

Name of auto insurance company: _____

Address: _____

Phone number: (_____) _____ - _____

Policy number: _____ Claim number: _____

5. Was another party responsible for this accident? YES NO

If YES, complete the following:

Name of insurance company: _____

Address: _____

Phone number: (_____) _____ - _____

Policy number: _____ Claim number: _____

6. Was this accident work related? YES NO

If YES, complete the following; Name of employer: _____

Address: _____

Phone number: (_____) _____ - _____

7. If this injury is work related, have you completed a *First Report of Injury* form? YES NO
If NO, please ask the front desk for the form.

If my injury resulted from any activities as indicated above, and I choose to not submit charges to any third party, I will be financially responsible for charges incurred. I understand that medical insurance coverage will not usually cover services related to injuries which may involve employment, an automobile, or another responsible third party.

COMPLETED BY: (print name) _____ DATE: _____/_____/_____

SIGNATURE _____