POCATELLO ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE
ORTHOPAEDIC SURGERY
333 NORTH 18TH AVENUE, SUITE D-1
POCATELLO, IDAHO 83201

DATE OF INJURY: _____

PLACE OF ACCIDENT: _____

DESCRIBE BRIEFLY HOW THE ACCIDENT OCCURRED:

_____
_____
_____

° Was the injury sustained while performing work required by your employer? _____
If yes, name of employer: _____ Phone #:_____
Name of Worker's Compensation carrier_____
Claim #: _____
Adjuster's name: _____
Phone #: _____

° Was the injury the result of a motor vehicle accident? _____
If yes, are you covered for medical expenses through your automobile insurance policy? _____
Name of insurance company: _____
Claim adjuster's name: _____
Phone #: _____

° Is there an attorney involved with your accident?
If yes, name of attorney:_____
Phone #: _____

SIGNATURE: _____ Date: _____

Home Phone: _____ Business Phone: _____