WASHINGTON ORTHORPEDICS & SPORTS MEDICINE
LIABILITY COVERAGE INFORMATION

Please provide all necessary information. If incomplete or invalid, you will be billed for the office visit and any and all procedures.

Name: Last, First, MI _____**Home Phone:**_____

Street Address:_____ **Cell Phone:** _____

City: _____**State:**_____**Zip Code:** _____ **Business Phone:**_____

SS#:_____**Birth Date:**_____**Pharmacy:** _____

Occupation:_____**Date of Accident:**_____**Pharmacy Phone:**_____

Body part(s) injured and/or affected:_____

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WORKERS COMPENSATION COVERAGE

Employer's Name:_____Employer Contact Person:_____

Company Address:_____City, State, Zip Code:_____

Employer Phone #:_____**Employer Fax #:**_____**Claim #:**_____

Insurance Company Name:_____

Insurance Company Address:_____

City:_____State:_____Zip Code:_____

Adjuster's Name:_____Adjuster's Phone #:_____Ext:_____

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AUTO ACCIDENT COVERAGE

Inusrance Company Name:_____Ins. Co. Phone #:_____

Ins. Co. Address:_____

City, State, Zip Code:_____**Claim #**:_____

Insurance Co. Claim Address:_____

City:_____State:_____Zip Code:_____

Adjuster's Name:_____Adjuster's Phone #:_____Ext:_____