

# ATTENDING PHYSICIAN'S REPORT

Date: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER THE AUTOMOBILE PERSONAL INJURY PROTECTION LAW, THE ATTENDING PHYSICIAN MUST COMPLETE THIS REPORT AND RETURN IT DIRECTLY

Physician's Name: \_\_\_\_\_ Hospital or Office Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Occupation: \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION: PLEASE FURNISH THE FOLLOWING REPORT REGARDING MY CONDITION AS A RESULT OF THIS ACCIDENT WHICH OCCURRED ON \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature Date

## TO BE COMPLETED BY ATTENDING PHYSICIAN

History of Occurrence as described by the patient: \_\_\_\_\_

Diagnosis and concurrent conditions: \_\_\_\_\_  
\_\_\_\_\_ If x-rays taken where? \_\_\_\_\_

When did symptoms first appear? \_\_\_\_\_

When did patient first consult you for this condition? \_\_\_\_\_

Has the patient ever had same or similar condition? YES  NO  If "yes" state when and describe below: \_\_\_\_\_

Is condition solely a result of this accident? YES  NO  If "no" please explain below: \_\_\_\_\_

Nature of surgical procedures and dates, if any: \_\_\_\_\_

Charge to patient for this procedure including post care: \$ \_\_\_\_\_ Location of procedure: \_\_\_\_\_

Is condition due to injury or sickness arising out of patient's employment? YES  NO

Will injury result in permanent disfigurement or disability? YES  NO  If "yes" describe below: \_\_\_\_\_

Patient was disabled (unable to work) from \_\_\_\_\_ through \_\_\_\_\_

If still disabled, date patient should be able to return to work \_\_\_\_\_

Other medical services and charges: Service \_\_\_\_\_ Charge.....\$ \_\_\_\_\_  
Service \_\_\_\_\_ Charge.....\$ \_\_\_\_\_  
Total Charges to Date.....\$ \_\_\_\_\_

Is patient still under your care for this condition? YES  NO  Estimated Future Charges.....\$ \_\_\_\_\_

Physician's Name (Print) \_\_\_\_\_ IRS Identification Number: \_\_\_\_\_

Physician's Street Address: \_\_\_\_\_ City, State, Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date