COLORADO WEST OTOLARYNGOLOGIST, P.C.
425 Patterson, Suite 503 ◆ Grand Junction, CO 81506
(970) 245-2400 ◆ 1-800-247-5221 ◆ Fax (970) 242-9092

Injury Information Sheet

Patient Name ______________________________ Date of Birth ____________________

Reason Being Seen? ____

Date of Injury ____

How did this injury happen? ____

____

Where did this injury happen? ____

____

Work Related ☐ Yes ☐ No (If no, skip this section.)

Employer's Name ____
Employer's Address and Phone # ____

____
Claim # ____________________ Name of Contact Person ______________________
Was Employer Notified ☐ Yes ☐ No

Auto Related ☐ Yes ☐ No (If no, skip this section.)

Name of Auto Insurance ____
Auto Insurance Address and Phone # ______________________________________

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Claim # ____________________ Name of Contact Person ______________________

Name of Insurance for this Injury ____
Address and Phone # ____

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Claim # ____________________ Name of Contact Person ______________________

Other Insurance name ____
Address and Phone # ____

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Claim # ____________________ Name of Contact Person ______________________

The information listed above is accurate to the best of my knowledge. I hereby authorize Colorado West Otolaryngologists to disclose all medical records pertaining to me and hereby release Colorado West Otolaryngologists from any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, or peer review body, or the delegated agent of any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review, or other similar activity. I hereby authorize messages regarding appointments with this office to be left on my telephone answering machine or with a family member. I understand that I am ultimately responsible for any of my charges, regardless of insurance coverage. I authorize payment directly to Colorado West Otolaryngologists, P.C. of any benefits payable to me for services rendered.

Patient's Signature ______________________________________ Date ______________

******YOUR INSURANCE MUST HAVE THIS INFORMATION TO PROCESS CLAIMS******