



ORTHOPEDIC PARTNERS

Date: _____ Date of Injury: _____

Patient: _____ Place of Injury: _____

Provider: _____ Work Related? _____ Yes / _____ No

Account #: _____ Auto Accident: _____ Yes / _____ No

Insurance: _____ ID: _____

Subscriber: _____

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy
(this means the auto insurance pays as your primary insurance)

_____ I have no Auto Med Pay Insurance
(this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / _____ No

What did you injure? (example: left arm) _____

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including how and where it occurred as required by your insurance:

Signature _____ Witnessed _____

(860) 889-7345

(860) 963-2133

82 New Park Avenue
North Franklin, CT 06254

11 Industrial Park Road
Niantic, CT 06357

35 Kennedy Drive
Putnam, CT 06260

5 Founders Steet
Willimantic, CT 06226