Patient Name:      Account No.:       Today’s Date:      Doctor:

Workers’ Compensation Information

Employer’s Name:      Tele. No.:       Address:            

Number & Street City/State Zip Code

Employer’s Comp. Insurance Carrier:

Tele. No.:

Address:            

Number & Street City/State Zip Code

Your Job Injury Claim Number:

Date of Injury:

Attorney Information

Name:       Firm Name:      Tele. No.:       Address:            

Number & Street City/State Zip Code

Third Party Liability

PLEASE LIST NAME OF THIRD PARTY LIABILITY IF THIS CLAIM IS DUE TO ACCIDENT NOT RELATED TO JOB INJURY OR AUTO

ACCIDENT (i.e., injury due to falling in parking lot, sidewalk, etc.)

Third Party Liability Name:

Auto Accident Information

PLEASE ANSWER THESE QUESTIONS ABOUT THE VEHICLE IN WHICH YOU WERE DRIVING OR RIDING:

Owner’s Name:       Address:            

Number & Street City/State Zip Code

State Where Is Vehicle Registered:       Auto Insurance Company:

Date of Accident:       Tele. No.:

Address for Claim:            

Number & Street City/State Zip Code

Policy Number:       Claim Number:

Please Read & Sign

PLEASE COMPLETE THE FOLLOWING AUTHORIZATION & ASSIGNMENT FORM FOR CLAIMS UNDER MARYLAND’S “NO FAULT” (“PERSONAL INJURY PROTECTION”) COVERAGE:

I,      , authorize my physicians at Shady Grove Orthopaedics to furnish the insurance company listed above any information it may request in reference to the injuries sustained by me, my spouse, or children on:       .

(date)

I also request that the insurance company pay directly to Shady Grove Orthopaedics any “PIP” benefits due me on their bill for professional services rendered in connection with these injuries.

Signature:

Date:

Office Use

Initiated By:

Date:

Posted:       Date:

Ref. Phys. No.:

9715 Medical Center Drive, Suite 415, Rockville, MD 20850 Main Tel. No. (301) 340-9200 Main Fax No. (301) 340-6934 Federal Tax ID: 52-1061922