Patient Name: _____

| | | |
|---|---|---|
| **Is your visit today the result of an automobile accident or other third party liability claim?** | ❑ Yes | ❑ No |
| **Is your visit today the result of a work-related injury?** | ❑ Yes | ❑ No |
| **Did your injury occur on the job or while you were working?** | ❑ Yes | ❑ No |

Please be advised that if you are seeing one of our physicians or physical therapists today for a work-related injury or a personal liability claim, you **MUST NOTIFY the front desk receptionist immediately**. If you fail to notify us of such a claim, your health insurance may deny coverage and you will ultimately be responsible for all charges related to medical care you receive at MAX Sports Medicine.

We maintain strict guidelines on the processing of work-related and personal liability claims. In order to process paperwork in a timely manner, we must know on your first visit if your injury is work-related or the result of a personal liability claim.

**Again, if you do not notify us that your visit today is work-related or the result of a third party liability claim, you may ultimately be responsible for all charges incurred at MAX Sports Medicine.**

We appreciate your cooperation in this important matter. Please let us know if you have any questions.

Patient Signature: _____ Date: _____

**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST**

PATIENT IDENTIFICATION LABEL

**MAX SPORTS MEDICINE**

**PATIENT INJURY QUESTIONNAIRE**