INITIAL INSURANCE REPORT

Date _____

To (Carrier Name) _____

Address _____ City _____ State _____ Zip _____

Patient Name _____

Address _____ City _____ State _____ Zip _____

Insured Group or I.D. No. _____ Claim No. _____

Employer _____ Date of Accident/Injury/Onset _____

Date of First Office Visit _____ No. of Visits to Date _____

1. History of Injury, Accident, Onset _____

2. Complaint of Patient (Subjective Complaints) _____

3. Objective Examination Findings _____

4. X-Ray Summary, Date of Film, Outside Film on File, Findings _____

5. Diagnosis (ICD-9-CM) _____

6. Treatment Goals _____

7. Referral Comments _____

8. Initial Patient Response to Treatment _____

9. Disability Date _____

10. Additional Comments _____

EXAMINATION FORMS ATTACHED	☐ Yes	☐ No	X-RAY REPORT ATTACHED	☐ Yes	☐ No
INSURANCE CLAIM ATTACHED	☐ Yes	☐ No	ACCIDENT REPORT ATTACHED	☐ Yes	☐ No
ADDITIONAL EVALUATIONS ATTACHED	☐ Yes	☐ No			

Doctor's Name (Typed) _____ Date _____

Doctor's Signature _____

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