NORTHERN INDIANA HAND&WRIST CENTER

Name: _____ DOB: _____

Is Your Condition or Injury Related to Work?	◯ Yes	◯ No
Is Your Condition or Injury Related to an Auto Accident?	◯ Yes	◯ No
Is Your Condition or Injury Related to a Fall on Someone Else's Property?	◯ Yes	◯ No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, AND YOU HAVE **NOT** PROVIDED OUR OFFICE WITH WORKERS COMPENSATION, AUTO LIABILITY OR COMMERCIAL LIABILITY INSURANCE INFORMATION, PLEASE RETURN TO THE FRONT DESK.

Check One:

☐ I agree that the condition and/or injury for which I am seeking evaluation and treatment **IS NOT** the result of my employment, an auto accident or fall/injury on someone else's property.

☐ I agree that the condition and/or injury for which I am seeking evaluation and treatment **IS** the result of my employment, an auto accident or fall/injury on someone else's property AND I have provided NIHW with claim information and/or am paying cash for today's appointment.

_____ _____

Patient Signature *Date*