Convenient Care Family Medicine
2216 W. Washington, Stephenville, TX 76401
Kelly S. Doggett, MD 254-965-5888

www.vourhometowndoctor.com

INJURY DETAILS REPORT

Please complete this portion of the form **only** if you **DO NOT** have an injury.

❑ My pain or symptoms are not due to an injury. _____
Signature Date

Do not complete the rest of the form. Please sign & return to receptionist.

_____ _____
Patient Name: Social Security #

_____ _____ _____
Address Apt# City State Zip Birth Date: Sex

_____ _____
Phone # Date of Injury

Type of Accident or Injury:

- ❑ Auto Accident _____
- ❑ Sport related / Type of Sport _____
  - School related_____ _____
    Name of school Coach/Trainer
  - Recreational_____
- ❑ Work related injury / if so,

  _____
  Company Name Phone # Supervisor's Name
- ❑ Other _____

_____ _____
Where did injury occur? Part of Body injured

Describe how the injury occurred? _____
_____

_____ _____
Date of First Treatment: By Whom:

INSURANCE INFORMATION

Insurance Co. Name & Address: _____

Phone # _____ Policy # _____

Name & Address of Policyholder: _____

Relationship to the Patient: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be directed to the Provider of Service "**Kelly S. Doggett, MD**" from my Insurance Co. _____ and direct any and all payments to be mailed to: **Convenient Care Family Medicine, 2216 W. Washington, Stephenville, Texas 76401.** In the event that the check is made payable to myself, I hereby authorize said provider to endorse said payment on my behalf and post payment to my patient account.

_____
Date Patient Signature (If 18 Years or older) or Parent/Guardian

_____
Witnessed this date by: