R. Douglas Bostick III, M.D.
3001 Division Street, Suite 204 Metairie, LA 70002
Phone: 504.541.5800 Fax: 504.541.5801

ACCIDENT INFORMATION

Patient Name:____

Type of Injury:____

Date of Accident:____

How did the Accident Occur?

____

Where Did Accident take place?____

Third Party Insurance Company____

Address:____

Policy Number:_____________________________ Claim Number:_____________________________

Insured Name:____

Agent/Contact:__________________________Phone:____

I authorize payment of medical benefits to Metairie Orthopedics & Sports Medicine for services rendered. Should my health insurance company or third party not pay charges associated with the above Accident, I understand that I will be financially responsible for payment on this account. I hereby Authorize Jefferson Orthopedic Clinic to release all information regarding my medical care to the above third party for all charges related to this accident date.

Date _____________________ Signature _______________________________________