STEVEN E. NOLAN, M.D.
ARTHUR F. CHAU, M.D.

Date: _____

PLEASE FILL OUT THIS REPORT
PLEASE ESTIMATE DATE OF FIRST SYMPTOMS

Dear Patient:

The following accident details may be required by your insurance company in order to process your claim. Helping us to gather this information prior to our office submitting your claim will enable us to assist you in getting your insurance company to pay your claim in a timely manner.

Patient:	Insured:
Insured's I.D. #:	Group/Policy #:

Briefly describe where and how the accident/illness occurred. This must be completed to get your claim paid.

What was the date and time of the accident or the first date of symptoms? Please estimate if you are unsure.

Date:	Time:

Was the accident/illness work related? (circle one): Y N Sports related? (circle one): Y N

Patient's Signature or **Date**
Parent/Guardian's if patient is a minor