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 the accident take place?_____

Third Party Insuarnce 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 Metairie Orthopedics & Sports Medicine to release all information regarding my medical care to the above third party for all charges related to this accident date.

Date_____ Signature_____