LOUIS F. CLARIZIO, DDS PA
ORAL SURGERY & DENTAL IMPLANT CENTER
Diplomate, American Board of Oral & Maxillofacial Surgery

ACCIDENT MEDICAL CLAIM FORM

TO BE COMPLETED BY INSURED MEMBER

Policy/Plan Number: ____

Name of Injured Member: ______________________ Alternate Name: ______________________

Address: ____
(Street) (City) (State) (Zip Code)

Phone Number: (______) ______ - ___________ Date of Birth: _____ / ______ / ______

Social Security Number: ____________________ Identification Number: ______________________

Patient's Name and Relationship (If other than Insured Member): ______________________

Patient's Date of Birth: _____ / ______ / ______ ❑ Male ❑ Female

1. Date of Accident: _____ / ______ / ______ 1a. Hour: ______ : ______ ❑ AM ❑ PM

2. Description of Accident
   A) How did it occur? ____

   ____

   B) Where did it occur? City: _______________ State: _____ Location: _______________

   C) Nature of Injury: ____

3. Were you hospitalized? ❑ Yes ❑ No

3a. If yes, please give Name and Address of Hospital: ______________________

4. Did this accident occur while playing in an Organized Sport? ❑ Yes ❑ No

5. Was this a work related accident/injury? ❑ Yes ❑ No

5a. If yes, has this been filed with Worker's Compensation? ❑ Yes ❑ No

6. Have you ever had this Condition before? ❑ Yes ❑ No

6a. If yes, please give month, date and year: _____ / ______ / ______

7. Is the Patient covered by any other plan for expenses related to this accident? ❑ Yes ❑ No

7a. If yes, please give the following information of the Insurance Carrier:
   Name: ____

   Address: ____
   (Street) (City) (State) (Zip Code)

   Phone Number: (______) ______ - ___________ Policy Number ______________________

   Effective Date: _____ / ______ / ______ Termination Date (if applicable): _____ / ______ / ______

PLEASE NOTE: Incomplete claim forms will result in process delay.

I understand that this information will be used by Dr. Louis Clarizio for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Member Signature: ____________________ Print Name: ____________________ Date: ____ / _____ / _____

REVIEWED ❑ ____