QUEEN'S ISLAND URGENT CARE

OFFICE USE ONLY
CLINIC LOCATION: _____ VISIT ID: _____
VISIT DATE/TIME: _____ STAFF INITIALS: _____

QIUC ACCIDENT AND INJURY FORM

Please provide us with the following information relating to your accident and/or injury. Please be as detailed as possible, as this information is necessary for your visit(s) to process efficiently.

PATIENT NAME: _____ DATE OF BIRTH: _____

1. DATE OF INJURY/ACCIDENT: _____ TIME: _____ AM / PM
2. PLACE OF OCCURRENCE (PLEASE CHECK ONE):
   - □ HOME – LOCATION (KITCHEN, BACKYARD, ETC.): _____
   - □ WORK – LOCATION (STOCK ROOM, JOBSITE, ETC.): _____
   - □ SCHOOL – NAME OF SCHOOL: _____
   - □ MOTOR VEHICLE ACCIDENT – STREET NAME/AREA: _____
   - □ OTHER – PLEASE SPECIFY (E.G. BEACH, PARK, ETC): _____
3. HOW DID THE INJURY OCCUR? WHAT CAUSED IT TO HAPPEN? (*PLEASE BE SPECIFIC*):
   _____
   _____
4. WHAT BODY PART WAS INJURED? *(PLEASE BE SPECIFIC)*:
   _____ □ RIGHT □ LEFT
5. IN WHAT WAY IS THE BODY PART INJURED? (*E.G.: WRIST IS SWOLLEN WITH REDNESS & BRUISING*)
   _____
   _____
6. IS THIS VISIT YOUR FIRST TIME RECEIVING TREATMENT FOR THIS INJURY?
   - □ YES
   - □ NO – FACILITY TREATED AT: _____ DATE: _____
7. DO YOU BELIEVE ANOTHER PERSON(S) OR PARTY IS, OR MAY BE, RESPONSIBLE FOR YOUR INJURY?
   - □ YES – PLEASE NOTE: QIUC WILL NOT BILL ANY THIRD PARTY FOR SERVICES. YOU WILL BE REQUIRED TO PAY IN FULL ON DAY OF SERVICE, AND WILL BE PROVIDED AN ITEMIZED RECEIPT. YOU WILL BE RESPONSIBLE FOR COLLECTING PAYMENT FROM THIRD PARTY.
   - □ NO

PLEASE READ THE FOLLOWING CAREFULLY

YOUR INSURANCE PLAN WILL MAIL YOU A SIMILAR QUESTIONNAIRE. IF YOU FAIL TO COMPLETE THE INSURANCE QUESTIONNAIRE, THEY WILL NOT PAY YOUR CLAIM AND YOU WILL BE RESPONSIBLE FOR THE ENTIRE COST OF YOUR VISIT.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE: _____ DATE: _____

PARENT/LEGAL GUARDIAN: _____ RELATIONSHIP TO PATIENT: _____