



CAROLINA ORTHOPAEDIC CENTER

MICHAEL J. O'BOYLE, M.D.
Acute Trauma • Post Traumatic Reconstruction
Foot & Ankle Surgery

THOMAS B. PACE, M.D.
Arthritic Hip & Knee Surgery

ALAN G. POSTA, JR., M.D.
Sports Medicine • Shoulder, Elbow & Knee
Reconstructive Surgery

H. STANLEY REID, M.D.
Spine Surgery

COMPLETE ACCIDENT DETAILS

PATIENT NAME: _____ SS#: _____

INITIAL DATE OF SERVICE: _____

Are you being seen today for an injury or accident? *(please circle)* YES NO

Was treatment necessary as a result of injury while on the job? *(please circle)* YES NO

If yes, Employer at time of injury _____

Has claim been filed with workman's comp? *(please circle)* YES NO

Workman's comp carrier _____

If above questions are NO please sign and date below.

If the above questions are YES, please complete the following:

Describe how the injury or accident occurred: _____

Is your injury a direct result of an accident? *(please circle)* YES NO

Date of accident: _____ Place of accident: _____

Did injury occur as result of a motor vehicle accident or other type of accident that was caused by someone else? *(please circle)* YES NO

Name and address of person causing injury: _____

Signature

Date