HSR
Health Special Risk, Inc.

Medical Accident Questionnaire

Do not leave any questions blank. Please provide as much detail as possible

A. PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth(MM/DD/YY)
Student ID Number: 999-	School Name:
First Date of Injury:	Date physician was seen for this injury:

Detail description of how injury occurred : *(Use back if more space is needed)*

Where injury occurred:

What injuries did you sustain as a result from this accident?

Were you under the influence of drugs or alcohol at the time of the accident? ☐ YES ☐ NO

Was any other person responsible for your accident? ☐ YES ☐ NO
If YES, please explain:

******If this accident was related to a Motor Vehicle Accident, please attach copy of official police report if applicable******

Was this a sports related injury? ☐ YES ☐ NO
If YES, ***(check the choice that applies)*** was this a ☐ **collegiate sports program** or ☐ **recreational sport**?
******If this injury was in result of a collegiate sports program, please provide Athletic Injury Report from Athletic Director******

B. PRIMARY PHYSICIAN(s) INFORMATION

Please list name(s) and phone number(s) for ALL physicians seen for the above injury. *(Use back if more space is needed)*

Physician Name	**Physician Phone Number**	**History of Treatment** (ALL Medication and Surgical Procedures)

C. OTHER COVERAGE

Is there another insurance plan with potential financial liability for this injury? (Workman's Compensation, Automobile or Property Insurance)
☐ YES ☐ NO **If YES, please attach details (Policy Name, Policy Number and Contact Number) of other insurance information.**

D. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Patient Signature _____ Date _____

Return to: Health Special Risk, Inc. ♦ 4100 Medical Parkway ♦ Carrollton, TX 75007 ♦ Phone: (866) 345-0974