

Salinas Valley Orthopedics & Sports Medicine, Inc.

A Medical Corporation
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ACCIDENT & INJURY REPORT

What is the reason for your visit today? (Please provide a brief description of your condition).

_____ .

Is your condition a result of an accident or an injury? Yes No

If not, when did your symptoms begin? ____/____/____ . *If your answer is no to the above, please skip questions 1 –5, sign and date this form.*

If your condition is related to an accident or injury, please answer the following questions:

1. Date of accident/injury: ____/____/____

2. Is this an on-the-job accident/injury? Yes No

3. Is your condition a result of an automobile accident? Yes No

4. Where did your accident/injury take place: _____

5. Please provide a brief description of how your accident/injury occurred:

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

PATIENT/PARENT SIGNATURE: _____ DATE: _____