



## **Slip & Fall Questionnaire**

Patient \_\_\_\_\_ Date \_\_\_\_\_ Accident Date \_\_\_\_\_

Accident Time \_\_\_\_\_ Location \_\_\_\_\_

Describe Accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Person \_\_\_\_\_ Report Made? **Yes** **No**

Insurance Co. \_\_\_\_\_ Claim #: \_\_\_\_\_

Other doctors seen for this accident \_\_\_\_\_

Attorney Involved \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Additional Notes \_\_\_\_\_

\_\_\_\_\_

Doctor Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature