SWEDISH

ACCIDENT / INJURY CLAIM

PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)	Date of Birth

Type of Claim

☐ Work ☐ Auto ☐ Other _____

Insurance Company Name	Claim # / Policy #
Date of Injury / Accident	What state did it occur in?
Claim Manager / Adjuster Name	Phone Number
Employer at time of injury (if work related)	Phone Number

Briefly describe how the injury occurred

Print Name	Date

Patient Signature

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

Official Use

Swedish NC 0004 ADMIN (Rev. 6/29/2018)

PLACE PATIENT LABEL HERE

Today's Date:

Patient Name:

MRN: Date of Birth: