# ATTENDING PHYSICIAN'S REPORT

Date: _____ Policy Holder: _____ Date of Accident: _____

TO ASSIST US IN DETERMINING BENEFITS DUE UNDER THE AUTOBOMILE PERSONAL INJURY PROTECTION LAW, THE ATTENDING PHYSICIAN MUST COMPLETE THIS REPORT AND RETURN IT DIRECTLY

Physician's Name: _____ Hospital or Office Name: _____
Street Address: _____ City, State, Zip Code: _____

**TO BE COMPLETED BY ATTENDING PHYSICIAN**

Patient's Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ Occupation: _____

History of Occurrence as described by the patient: _____

_____

Diagnosis and concurrent conditions: _____

_____

When did symptoms first appear? _____

When did patient first consult you for this condition? _____

Has the patient ever had same or similar condition? YES ☐ NO ☐ If "yes" state when and describe below:

_____

Is condition solely a result of this accident? YES ☐ NO ☐ If "no" please explain below:

_____

Is condition due to injury or sickness arising out of patient's employment? YES ☐ NO ☐

Will injury result in permanent disfigurement or disability? YES ☐ NO ☐ If "yes" describe below:

_____

Patient was disabled (unable to work) from _____through_____

If still disabled, date patient should be able to return to work _____

REPORT OF SERVICES

| Date of Service Charge | Place of Service | Description of Service | Amount of Service |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |

Total Charges to Date……...$_____

Is patient still under your care for this condition? YES ☐ NO ☐ Estimated Future Charges…….$_____

Physician's Name (Print) _____ IRS Identification Number: _____

Physician's Street Address: _____ City, State, Zip Code: _____

_____ _____

Physician's Signature Date

Form 1230F

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