PRO IMAGING, Inc.

PATENT INFORMATION FORM

FILE:

PHYSICIAN: _____

LAST NAME: _____ **FIRST NAME:** _____

STREET ADDRESS: _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

DATE OF BIRTH: _____/M/ _____/D/ _____/YR/

DATE OF ACCIDENT: ___ /M/___ /D/ _____ /YR/ **TYPE OF INSURANCE:** □PIP □PPO

NAME OF INSURED: _____

PRIMARY INSURANCE: _____

ADDDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

POLICY# _____ **CLAIM/GROUP #** _____

ADJUSTER'S NAME: _____ **TELEPHONE:** _____ **EXT:** _____

OTHER: _____

ATTORNEY: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **TELEPHONE:** _____

PATIENT INFORMATION

□ **NO RED FLAGS**

HISTORY OF FRACTURE: □ **YES** □ **NO** **DATE:** _____

HISTORY OF SURGERY: □ **YES** □ **NO** **TYPE:** _____

HISTORY OF MEDICATIONS (corticosteroids): □ **YES** □ **NO**

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