



ORTHOPAEDIC CENTER OF SOUTH FLORIDA  
LIABILITY PATIENT INFORMATION

PHYSICIAN \_\_\_\_\_  
NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MIDDLE LAST  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ BEEPER \_\_\_\_\_ CELLULAR \_\_\_\_\_  
AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ MARITAL STATUS S M W D  
SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_  
YOUR OCCUPATION \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
PARENT/SPOUSE NAME \_\_\_\_\_ PHONE \_\_\_\_\_

---

ACCIDENT INFORMATION

DATE OF ACCIDENT \_\_\_\_\_  
PLACE OF ACCIDENT \_\_\_\_\_  
SEATING OF PATIENT AT TIME OF THE ACCIDENT  
DRIVER \_\_\_\_\_ FRONT SEAT PASSENGER \_\_\_\_\_ REAR SEAT PASSENGER \_\_\_\_\_  
WERE YOU TREATED PREVIOUSLY FOR THIS INJURY? YES \_\_\_\_\_ NO \_\_\_\_\_  
HOSPITAL \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_