

## ATTENDING PHYSICIAN'S REPORT

DATE:	PATIENT'S NAME:	ACCIDENT DATE:	FILE NO.
-------	-----------------	----------------	----------

THIS PHYSICIAN'S STATEMENT MUST BE COMPLETED BY THE ATTENDING PHYSICIAN BEFORE BENEFITS THAT MAY BE DUE THE PATIENT CAN BE DETERMINED. PLEASE RETURN THE COMPLETED FORM TO:

\_\_\_\_\_  
CLAIMS DEPARTMENT

**CURE  
214 CARNEGIE CENTER  
SUITE 101  
PRINCETON, NJ 08540**

1. PATIENT'S NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)
--------	--------	--------------------------

5. HISTORY OF OCCURRANCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS AND CONCURRENT OR CONTRIBUTING CONDITIONS\*

7. WHEN DID SYMPTOMS FIRST APPEAR?	8. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:
------------------------------------	---

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?  
 YES ( ) NO ( ) If "YES", State when and describe\*

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT?  
 YES ( ) NO ( ) If "NO", Explain\*

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?  
 YES ( ) NO ( )

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR DISABILITY?  
 YES ( ) NO ( )

13. PATIENT WAS DISABLED (Unable to work) From: _____ Through: _____	14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:
---	---

15. REPORT OF SERVICES\*

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES
			\$
			\$
			\$
<b>TOTAL CHARGE TO DATE</b>			\$
16. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ( ) NO ( )		<b>ESTIMATED FUTURE CHARGES</b>	

**ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.**

DATE                      PHYSICIAN'S NAME (PRINT)                      PHYSICIAN'S SIGNATURE                      IRS/TIN IDENTIFICATION NO.

NO.                      STREET                      CITY OR TOWN                      STATE                      ZIP CODE

\*use reverse side if additional space is needed.