

NEW PALTZ PODIATRY

243 Main Street Suite 250

New Paltz, NY 12561

Patient Name: _____

BILLING INFORMATION FOR: ____ No Fault (auto) ____ Worker's
Compensation

Date of Injury / Accident: _____

Place of Injury / Accident: _____

Description of Incident: _____

Injured body part (s): _____

Worker's Compensation:

Employer: _____

Date injury was reported to employer: _____

To Whom: _____ phone # _____

Worker's Compensation or Auto Insurance Information:

Insured's Name: _____ (if other than patient)

Insurance Carrier Name: _____

Address/City/State/Zipcode _____

Phone # () _____

Claim # _____ Policy Id # _____

Claim Representative Name: _____ Extension _____