



U.D.M.I.
UNIVERSITY DIAGNOSTIC MEDICAL IMAGING, P.C.

NO FAULT & WORKERS COMPENSATION QUESTIONNAIRE

Today's Date: _____ UDMI Acct #: _____

Patient Name: _____

Patient Address: _____

Patient Mobile #: _____ Patient Home #: _____

Patient Date of Birth _____

Patient Employer: _____

Employer Telephone #: _____

Date of Accident: _____

Are you a Cab Driver or DRIVE you drive any type of vehicle for a living? YES _____ NO _____

Did you report your injury? _____

Were you a passenger, driver or pedestrian? _____

What part of your body did you report was injured? _____

Have you received any independent medical exams regarding this accident? _____

Liability Insurance Carrier (N/F or W/C) _____

Address _____

Telephone #: _____

Adjuster _____

Claim #: _____

Private Insurance Company _____

ID #: _____