NOTIFICATION OF INJURY

A.W.G. DEWAR, INC.
4 Batterymarch Park, Quincy, MA 02169
617-774-1555

Only one notification of injury form is required to be filed per injury.

STUDIENT INFORMATION:

NAME (LAST) (FIRST)

DATE OF BIRTH MALE ☐ FEMALE ☐

SOCIAL SECURITY NUMBER OF STUDENT

SCHOOL STUDENT ATTENDS:
UMS-WRIGHT PREPARATORY SCHOOL

PARENT/ GUARDIAN NAME & ADDRESS (Please Print Clearly)

TELEPHONE #

ACCIDENT INFORMATION:

NOTE: IF TOOTH INJURY, PLEASE ADVISE WHICH TOOTH AND ATTACH SIGNED ATTENDING DENTIST'S CERTIFICATION THAT TOOTH WAS SOUND AND NATURAL BEFORE INJURY.

DATE OF ACCIDENT | LOCATION OF ACCIDENT (Place) | STATE

DESCRIPTION OF INJURY (Specify left or right if applicable)

HOW DID ACCIDENT HAPPEN?

NAME AND ADDRESS OF PHYSICIAN(S)

PHYSICIAN(S) TELEPHONE #

TREATMENT COMPLETED
YES ☐ NO ☐

HAS THE ABOVE STUDENT SUFFERED SAME OR SIMILAR CONDITION / INJURY BEFORE?
YES ☐ NO ☐

IF PREVIOUSLY TREATED FOR THIS CONDITION / INJURY, GIVE BRIEF HISTORY INCLUDING DATES.

PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR IMPORTANT FRAUD INFORMATION REGARDING YOUR CLAIM.

PARENT SIGNATURE BELOW AUTHORIZES THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. A.W.G. DEWAR, INC. WILL PROTECT THE PRIVACY AND CONFIDENTIALITY OF THIS INFORMATION.

FORM TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN

SIGNATURE ______________________ DATE __________

PRINT NAME ______________________ TELEPHONE # __________

ADDRESS ______________________

Please complete this form and return the white and yellow copies to the address below. Retain pink copy for your records. Please forward itemized statements for medical services to our office for reimbursement. Itemized statements should include: date of service, service provided and cost of each service.

A.W.G. DEWAR, INC. 4 BATTERYMARCH PARK, QUINCY, MA 02169-7468

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