

Other Billing Information

Lincoln Internal Medicine Associates

Reason for Exam () Work Injury () Auto Accident () Employment Physical

Date of Exam _____

Name _____ Date of Birth _____

Address _____

Phone Number () _____ Social Security Number _____

Work Injury

Employer _____ Date of Injury _____

Supervisor/Contact _____ Work Number _____

Worker's Comp Carrier _____ Claim # _____

Address _____

Auto Injury

Policyholder _____ Relationship _____

Phone Number _____ Date of Injury _____

Auto Insurance Company _____ Phone # _____

Claim/Policy # _____

Address _____

Employment Physical

Employer _____

Supervisor/Contact _____ Phone Number _____

Address _____