



HARTFORD ORTHOPEDIC MEDICINE

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PERSONAL INJURY PATIENT REFERRAL INFORMATION

We're here to help with comprehensive attention to clinical applications and a dedicated medical-legal department designed to provide law offices with all the necessary documentation and expertise your office requires.

Complete this form with all the information you have readily available, and we'll take care of the rest!

Attorney	Law Firm:	Attorney Assigned to Case:	Paralegal or Case Manager:	Today's Date:
	Attorney Address:		City, State, Zip Code:	
	Direct Phone Number with Extension:	Fax Number:	Attorney E-Mail Address:	

CLIENT INFORMATION	Your Client / Our Patient Name (First, Middle, Last):		Date of Birth:	Date of Injury (Loss):
	Street Address:		City, State, Zip Code:	
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:	Driver's License or Other ID Number:	State:
	Main Phone Number:	Other Phone Number:	E-mail Address:	
	Secondary Contact Name and Relationship:		Secondary Contact Phone Number:	

Auto Insurance	Name of Automobile Insurance Company:		Name of Insured:	
	Policy Number:	Policy Limits:	Med-Pay or PIP Limits (If Known):	
	Accident Claim Number	Contact Name or Adjuster:	Adjuster or Other Contact Information:	

Health Insurance	Name of Health Insurance Company:		Name of Insured:	
	Insurance Company Address:		City, State, Zip Code:	
	Group, Plan, or Patient ID Number:		Insurance Company Phone Number:	

Fax or email this form along with your Letter of Protection, a records release authorization and any supporting documentation or medical records. We will share progress notes and account information with the indicated case manager/paralegal on regular intervals.

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