WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec.# _____

Address _____
Street City State Zip

Home Phone (____) _____ E-mail _____

Cell Phone (____) _____ Occupation _____

EMPLOYER

Employer Name _____

Employer Address _____
Street City State Zip

Employer Phone (____) _____ Injury Verified by (For Office Use) _____

Contact Person _____ E-mail _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____
Street City State Zip

Carrier Phone (____) _____ Coverage Verified by _____

Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ ☐ AM ☐ PM Place of Injury _____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to _____

Give full description of how accident happened _____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much? _____

Other doctors seen for this condition: Doctor's Name _____

Diagnosis _____ Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s) _____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries _____

Describe previous Worker Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date