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

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient