**Worker’s Compensation Patient Information**

(All areas must be filled out or you may be responsible for payment)

**Patient Name:**

**Social Security Number:**

**Date of Injury**

**Employer at Time of Injury:**

**Employer’s Address:**

**Job Title:**

**WCB Case Number:**

**Carrier Case Number:**

**Insurance Carrier Name and Address:**

**Contact Name:**

**Phone:**

**Fax (this comes from the adjuster):**

**Is the claim Open? (this info comes from the adjuster)**

**What areas are covered? (this info comes from the adjuster)**

**Currently working? Yes/No**

**Disability Status/rating (if known): Temporary/Permanent**

**Partial/Total**

**Percentage \_\_\_\_\_\_\_%**