WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec # _____

Address _____

_____

Telephone _____

EMPLOYER

Employer Name _____

Employer Address _____

_____

Employer Telephone _____ Injury Verified By (For Office Use) _____

Contact Person _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____

_____

Carrier Phone Number _____ 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 Workers Compensation benefits is denied.

Patient's Signature _____ Date _____