WORKERS COMPENSATION INFORMATION

Date: _____

PATIENT INFORMATION

Name: _____ Birthdate: _____ Soc. Sec. #_____
Address: _____
_____
Telephone:_____Occupation: _____

EMPLOYER

Employer Name: _____
Employer Address: _____
Employer Telephone: _____ Injury Verified By: _____
Contact Person: _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Workers Compensation Carrier: _____
Carrier Address: _____
Carrier Phone No: _____ 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: _____