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

(Address will be different from your employer's address)

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 doctor's 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____
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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: ________________________