WORKER COMPENSATION INFORMATION

Date: _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc Sec # _____

Address _____ City _____ Zip _____

Telephone _____ Occupation _____

EMPLOYER

Employer Name _____

Employer Address _____ City _____ Zip _____

Employer Telephone _____ Injury Verified by: _____

Contact Person _____

WORKER COMPENSATION CARRIER

Worker Compensation Carrier _____

Carrier Address _____ City _____ Zip _____

Carrier Phone Number _____ Coverage Verified by _____

Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____

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 test? ☐Yes ☐ No

If yes, by whom? Please list test and result(s) _____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date 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 responsible for payment in the event that my claim for Worker Compensation benefits is denied.

Patient Signature _____