WORKER COMPENSATION INFORMATION

PATIENT INFORMATION

Name: _____ Birthdate: _____ Soc. Sec. #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

EMPLOYER INFORMATION (At time of injury)

Employer Name: _____ Phone: _____
Employer Address: _____
Contact Person: _____ Verified by (office use): _____

WORKER COMPENSATION CARRIER

Work Comp. Carrier: _____
Carrier Address: _____
Carrier Phone Number: _____ Adjuster Name: _____
Claim Number: _____ Verified by (office use): _____

INJURY INFORMATION

Date of Injury: _____ Time: _____ ☐ AM ☐ PM
Place of Injury: _____
Accident reported to employer? ☐ Yes ☐ No
Name of person reported to:_____

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, where were they done? _____
Any previous Work Comp. injuries? ☐ Yes ☐ No Date (s) of injuries:_____
Briefly describe previous 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 Worker Compensation benefits is denied.

Patient Signature: _____ Date: _____