WORKER COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Soc. Sec. #_____

Address_____

_____

Telephone_____ Occupation_____

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_____