WORKERS COMPENSATION INFORMATION

Date___________________________________

PATIENT INFORMATION

Name____Birthdate____________________ Social Security #__________________
Address ____
Telephone (home) __________________________ (work)____________________________ Occupation______________________
EMPLOYER
Employer's Name ____
Employers Address ____
Employers Telephone # _____________________________________ Injury verified by____________________________________
Contact Person ____

CARRIER INFORMATION

Workers Compensation Carrier ____

Carrier Address ____
Carrier Phone Number____
Adjuster ____
Claim Number ____

INJURY INFORMATION

Date of Injury _____________________________________ Time_______________ ☐ AM ☐ PM
Place of Injury ____
Was Accident Reported to Employer? ☐ yes ☐ no Name of person who took accident report ______________________________
How did accident happen?
____
____
____
____
____
____
Have you lost time from work? ☐ yes ☐ no How much? ________________
Have you seen another physician for this condition? ☐ yes ☐ no
Doctor's Name ____ ____
Were x-rays taken? ☐ yes ☐ no Other test? ☐ yes ☐ no
If Yes, please list test and by
whom.____
____
Do you have any previous Workers Compensation Injuries, if yes, please explain
____
____

AUTHORIZATION

I hereby assign, transfer, and set over to _________________ all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature____Date_________________________