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 Only) ______________

Contact Person ____

WORKER COMPENSATION CARRIER (FOR OFFICE USE ONLY)

Worker Compensation Carrier(Insurance Co.) ______________________________

Carrier Address ____

____

Carrier Phone Number ______________________________ Coverage Verified by ______________

INJURY INFORMATION

Date of Injury ______________________________ Time ______________ ☐ a. m. ☐ p. м.

Place of Injury ____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to ______________

Give full description of how accident happened ______________________________

____

____

What body parts did you injure? ______________________________

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) ______________________________

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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 will promptly pay all charges in the event that my Worker Compensation benefits is denied.

Patient's Signature ______________________________ Date ______________