

# 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

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 \_\_\_\_\_