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 _____

Carrier Address _____

_____

Carrier Phone Number _____ **Coverage Verified by** _____

INJURY INFORMATION

Date of Injury _____ **Time** _____ ☐ **a.m.** ☐ **p.m.**

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

Patient's Signature _____ **Date** _____