

# 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.

Place of Injury \_\_\_\_\_  p.m.

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 \_\_\_\_\_