WORKERS COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Social Security #_____
Address_____
Telephone (home)_____ (work)_____ Occupation_____
EMPLOYER
Employer's Name_____
Employer's Address_____
Employer's 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_____