

# WORKER COMPENSATION INFORMATION

Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_

## EMPLOYER

Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer Phone (\_\_\_\_) \_\_\_\_\_ Injury Verified by (For Office Use) \_\_\_\_\_  
Contact Person \_\_\_\_\_ E-mail \_\_\_\_\_

## WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier \_\_\_\_\_  
Carrier Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Carrier Phone (\_\_\_\_) \_\_\_\_\_ 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 Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient