



**WORKER COMPENSATION INFORMATION**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

**EMPLOYER**

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer Phone: (\_\_\_\_) \_\_\_\_\_ Injury verified by: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_

**WORKER COMPENSATION CARRIER (for office use)**

Worker Compensation Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

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? Y\_\_ N\_\_ Name of person accident reported to: \_\_\_\_\_

Give full description of how accident happened:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you lost time from work? Y\_\_ N\_\_ How much?: \_\_\_\_\_

Other doctors seen for this condition: Doctor's name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ X-rays Y\_\_ N\_\_ Other Tests Y\_\_ N\_\_

If yes, by whom? Please list test(s) and result(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any previous Worker Compensation injuries? Y\_\_ N\_\_ Date(s) of previous injuries \_\_\_\_\_

**AUTHORIZATION**

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that my claim for Worker Compensation benefits are 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