Workers Compensation Information Sheet

Name:_____Birthdate:_____ SS#_____

Address:_____

Telephone:_____ Occupation:_____

Employer

Employer's Name:_____Employer'sAddress:_____

Employer's Phone:_____ Injury verified by:_____

Contact Person:_____ Their Phone: _____

Worker's Compensation Carrier

Who is your workers compensation carrier?_____

Address:_____

Telephone:_____ Coverage verified by:_____

Adjusters Name:_____ Claim #:_____

Injury Information

Date of injury_____ Place of injury_____

Was accident reported to an employer?_____ Person reported to:_____

Give a full description of the accident:

_____

_____

Have you lost time from work?_____ Dates:_____

Previous Doctors Seen For This Condition

Doctors Name_____ Diagnosis_____

Were x-rays taken?_____Any other tests?_____Test type and results_____

Any previous worker's compensation injuries?_____ List dates_____

Describe your previous injuries:_____

Authorization

I CLEARY UNDERSTAND AND AGREE THAT I WILL DIRECTLY BE CHARGE FOR ALL SERVICES RENDERED, AND THAT I AM RESPONSIBLE FOR PAYMENT IN THE EVENT THAT MY WORKER'S COMPENSATION BENEFITS ARE DENIED.

Patients Signature_____ Date_____