

WORKERS COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Social Security # _____
Address _____
Telephone (home) _____ (work) _____ Occupation _____
EMPLOYER
Employer's Name _____
Employers Address _____
Employers 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 _____