WORKERS COMPENSATION INFORMATION

Date ____/____/____

PATIENT INFORMATION

Name _____ Date of Birth ____/____/____ Social Security _____-_____-_____
Address _____City _____ State _____ Zip _____
Telephone _____ Cell _____ Occupation _____
Employer's Name _____
Employer's Address _____
Employer's Telephone _____ Injury verified by _____
Contact Person _____

CARRIER INFORMATION

Workers Compensation Carrier _____
Carrier Address _____
Carrier Telephone _____
Adjustor Name _____
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
Physicians Name _____
Were x-rays taken? □ yes □ no Any 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 authorize 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 ____/____/____

CARE PLUS
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