WORKERS COMPENSATION INFORMATION

Name:_____Date:_____

Address:_____Phone #:_____

Date of Birth:_____Social Security Number:_____(required for claim verification)

What is the date and time the injury occurred?_____

How long has your problem been present?_____

How did this accident happen?_____

What body part or parts are affected?_____

Are you currently working? (Full duty/Light duty)_____

Was your Employer notified at the time of the accident?_____

Have you completed an accident report with your employer? (**required)**_____

Employer Name:_____

Employer Address:_____

Employer Supervisor or other contact:_____

Employer Phone #:_____Employer Fax #:_____

Job Title:_____Job Duties:_____Duration of employment:_____

Is this injury with your current employer?_____If No, please explain:_____

Work Comp Insurance Information (Name, Contact Name, Phone #):_____

_____Claim#_____

Have you seen another Physician and/or had additional testing for this injury, briefly describe_____

_____

Do you have an attorney? If yes, please provide his or her name._____

Is your claim denied or disputed/in litigation for any reason?_____

Work Comp insurance information is required in order to bill your employer or your employer's insurance company. *If your claim is not accepted or payment is denied, you may be responsible for charges incurred. Private insurance may or may not, pay for services if the injury or symptom is reported as work related. Our facility prefers not to bill your private insurance unless a written denial is received from the work comp insurance carrier.*

Patient Signature:_____Date:_____