



PERSONAL INJURY INFORMATION

Date _____

Personal Injury Carrier

Personal Injury Carrier _____
Carrier Address _____
Carrier Phone (_____) _____ Coverage Verified by _____
Adjuster's Name _____ Claim Number _____
Attorney's Name _____
Attorney's Address _____

Injury Information

Date of injury _____ Time _____ AM PM
Place of injury _____
Was the incident reported to a supervisor? Yes No
Name of person you reported accident to _____
Describe the incident in 1-3 sentences _____

Have you lost time from work? Yes No How much? _____
Were you sent to see a doctor? Yes No
Other doctors seen for this condition: Doctor's name _____
Diagnosis _____
Were X-rays taken? Yes No Other Tests? Yes No
If Yes, by whom? Please list test(s) and result(s) _____

Are there problems that effect work? What? _____
Do you favor 1 side in work? Yes No If so, which side? _____
Before the injury did you do work equally to others your age? Yes No
Any previous injuries? Yes No
Date(s) of previous injuries _____
Describe previous injuries _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is 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 _____
Print name of Patient, Parent, Guardian or Personal Repres. _____ Relationship to Patient _____