# Worker Compensation Information

## Patient's Employer

Patient Name: _____ Date of Birth: _____ Today's Date: _____
Employer Name: _____
Employer Address: _____
Employer Phone: (  ) _____ Employer Email: _____
Injury verified by (For office use): _____
Contact Person: _____

## Worker Compensation Carrier

Worker Compensation 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 or PM
Place of Injury: _____
Was the incident reported to a supervisor (Please Circle): YES NO
Name of person you reported accident to: _____
Describe the incident in 1-3 sentences: = _____

Have you lost time from work (Please Circle): Yes No If yes, how much time: _____
Were you sent to see a doctor (Please Circle): Yes No
Have other doctors seen you for this condition – Doctor's Name: _____
Diagnosis: _____
Were X-rays or other tests taken (Please explain): _____
If yes, by whom were these tests taken: _____
Do these problems effect work (Please Circle): Yes No
Do you favor one side in work (Please Circle): Yes No If so, which side: _____
Before the injury did you work equally to others your age (Please Circle): Yes No
Any previous Worker Compensation injuries: Yes No
Date(s) of previous work-related injuries: _____
Describe previous Worker Compensation 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 Representative Date _____
Print Name: _____ Relationship to Patient: _____