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WORKERS COMP INFORMATION FORM

******THIS FORM MUST BE COMPLETED IF YOU ARE BEING SEEN FOR A WORK-RELATED INJURY******

Patient Name: ____Date: __________________

Social Security #: ___________________________ Date of Birth: _______________

Telephone: H) _____________________ (C) ________________________

Where were you employed at when injured? ____

Employer address: ______________________________City, State, Zip: ______________________

Employer phone #: ________________________HR Contact person: ________________________

Date of injury: ___________________Do you have a claim # if so what is it: __________________

Have you been able to work since injury? Yes____ No___

Have you completed a First Report of Injury? Yes___ No___ Physician of Record: Yes____ No____

Physician of Record: _______________________ Initial treatment at: ________________________

Managed Care Organization (MCO) or Self-Insured Company: ______________________________

Allowed condition(s) on claim: ____

Body part injured-indicate Right or Left: ____

Please give a description of how your injury occurred: _____________________________________
____

Check One: ___My on-the job accident was the one and only cause of my present condition

___My on-the-job accident aggravated a condition that already existed prior to my accident

Private Insurance Company Information: ____
ID# ____Grp#_______________________________________

I understand that if I do not provide my medical insurance and workers comp denies treatment that I am financially responsible.
Patient Signature: ____Date: ______________________