

Workers' Compensation Information

Patient Information

Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Occupation: _____ Sex: Male/Female Marital Status: _____
Height: _____ Weight: _____ B/P(Office Use): _____ Pulse(Office Use): _____

Employer Information

Employer Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Injury Verified By: HD/JG/TR/BM/MZ
Contact's Phone Number: _____ Fax: _____

Workers' Compensation Carrier (For Office Use)

Workers' Compensation Carrier: _____ Compensable Injury Below
Carrier Address: _____
City: _____ State: _____ Zip: _____ Verified: HD/JG/TR/BM/MZ
Carrier Phone Number: _____ Fax: _____
Adjuster: _____ Ext: _____ Claim#: _____

Injury Information

Date of Injury: _____ Day: _____ Time: _____ am/pm Date of Hire: _____
Place of Injury (Location & Department): _____
Was injury reported to your employer? Yes/No Have you lost time from work? Yes/No
How many days have you missed? _____ What dates were missed? _____
Name of person you reported your injury to: _____ (Supervisor/Manager?)
Give full description of how you were injured: _____

Gross Wages\$: _____ Hourly\$: _____ Weekly or biweekly\$: _____
Areas of your body that were injured: _____
Other doctors seen for this injury: _____
Phone Number: _____ Were X-Rays taken? Yes/No Other Tests? Yes/No
Name of witness that saw your injury: _____
Have you changed doctors before for this injury? Yes/ No If yes, what date: _____
Any previous workers' compensation injuries? Yes/No If yes, dates of injuries: _____
Describe previous workers' compensation injuries: _____

Authorization

Nearest Relative: _____ Relationship: _____ Phone: _____
Patient Signature: _____ Date: _____