Workers Compensation Form

Patient's Name___________________________________ Date of Birth: ____________________________________

Address: ____

____

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Today's Date: ____/____/________ Date of injury or illness: ____/____/________

Have you notified your employer of this accident/illness? ______________

Employer: ____

Address: ____

Worker's Comp contact in your company: ____

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Worker's Comp Insurance Company: ____

Address: ____

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Claim Number: ____

I authorize the release of any medial information necessary to process any Work Comp claims.

Signed: ____ Date: _________________________

Please Describe the accident and the injury that occurred:

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Please Note:
Your employer will be notified of all work comp claims prior to your appointment.