WORKERS COMPENSATION INFORMATION

Today's Date_____________________________________

PATIENT INFORMATION

Name____Birthdate_________________ Social Security #________________________
Address ____City/State_________________________ Zip_____________________
Telephone (home) ___________________________ (work)____________________________ (cell)______________________________
EMPLOYER
Employer's Name ____Occupation ____________________________________
Employers Address ____ City/State_______________________ Zip___________________
Employers Telephone # _______________________________________ Injury verified by______________________________________
Contact Person ____

CARRIER INFORMATION

Workers Compensation Carrier ____Date of Accident___________________________

Carrier Address ____
Carrier Phone Number____
Adjuster ____
Claim Number ____

INJURY INFORMATION

Date of Injury _______________________________________ Time________________ ☐ AM ☐ PM
Place of Injury ____
Was Accident Reported to Employer? ☐ yes ☐ no Name of person who took accident report ___________________________________
How did accident happen?
____
____
____
____
____
____
Have you seen a physician for this condition? ☐ yes ☐ no
Referring Doctor's Name _______________________________________Phone#____
Do you have any previous Workers Compensation Injuries, if yes, please list for the therapist.
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AUTHORIZATION

I hereby assign, transfer, and set over to CORVALLIS PHYSICAL THERAPY all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature____Date_____________________________