

# 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.

\_\_\_\_\_

\_\_\_\_\_

## AUTHORIZATION

I hereby assign, transfer, and set over to STEVENSVILLE 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 \_\_\_\_\_