

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 DRUMMOND 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 _____