ACCOUNT #_____

WORKERS COMPENSATION INJURY FORM

PATIENTS NAME _____**DOB**_____

DATE OF INJURY _____/_____/_____

JOB TITLE WHEN INJURED _____

AREA OF BODY INJURED _____

HOW INJURY OCCURRED & WHERE

_____

_____

_____

EMPLOYER NAME _____ **CONTACT NAME**_____

ADDRESS _____

CITY _____**STATE** _____**ZIP**_____

PHONE **(_____) _____ - _____**

DID YOU REPORT ACCIDENT TO EMPLOYER? YES NO (Circle One)
(If you have selected NO you will need to reschedule your appointment until this injury has been reported to your employer)

NAME OF WORKERS COMPENSATION CARRIER _____

ADDRESS _____

CITY _____STATE _____ZIP_____

PHONE (_____) _____ - _____ FAX # (_____) _____ - _____

CLAIM # _____WCB CASE # _____

PATIENT AUTHORIZATION:
I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

SIGNATURE:_____ **DATE:** _____