INSTRUCTIONS: If this is a Workers Compensation Injury, complete entire form. If this is <u>not</u> a work-related injury, simply sign and date In the last section of the form.

<u>Patient Information:</u>

Name: _____ SSN: ____/___/_____

Address: _____ Telephone:_____

<u>Employer Information:</u>

Name of Company:_____Contact Person:_____

Address: _____Telephone: _____

<u>Accident Information:</u>

Date of Injury: ____/_____/____ Location: _____

Nature of injury/illness: _____

<u>Managed Care Organization Handling Claim:</u>

MCO Name: _____Telephone: _____

Address: _____Case Manager: _____

<u>Workers Compensation Claim Information</u>:

Claim number: _____

<u>Attorney Information</u>:

Name: _____Telephone: _____

Address: _____

Patient Signature: _____ Date: _____

IF INJURY IS <u>NOT</u> RELATED to a workplace injury please sign and date below.
Please be advised that by signing below you will be responsible for payment of denied claims if this is indeed a work-related injury and you fail to inform our office.

Patient Signature: _____ Date: _____