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

Patient Information:

Name: ____ SSN: ____/___/______

Address: ____ Telephone:__________________

Employer Information:

Name of Company:_____________________________________Contact Person:________________________

Address: ____Telephone: _______________________

Accident Information:

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

Nature of injury/illness: ____

Managed Care Organization Handling Claim:

MCO Name: ____Telephone: ____________________________

Address: ____Case Manager: __________________________

Workers Compensation Claim Information:

Claim number: ____

Attorney Information:

Name: ____Telephone: ______________________

Address: ____

Patient Signature: ____________________________ Date: _________________

IF INJURY IS NOT 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: _________________

Rev 1/2013