WORKERS' COMPENSATION REGISTRATION FORM

DATE: ______________

PATIENT NAME: ____

ADDRESS: _________________________ CITY: ________________ ZIP: __________

PHONE: ______________________ SOCIAL SECURITY #: _____________________

DOB: ________________ AGE: _______ SEX: M ( ) F ( )

EMPLOYER NAME: ____

EMPLOYER ADDRESS: ____

EMPLOYER PHONE: ___________________ CONTACT PERSON: ______________

WORKERS' COMP INS CARRIER: _______________________________________

CARRIER ADDRESS: ____

CARRIER CASE #: ________________________ WCB# ________________________

DATE OF INJURY: ____________TOWN INJURY OCCURRED: _________________

HOW DID INJURY OCCUR? ____
____
____

WAS ACCIDENT REPORTED AT WORK? YES NO

WAS AN ACCIDENT REPORT FILED WITH WORKERS' COMP INSURANCE CARRIER?
YES NO

(IF THE ABOVE WAS NOT DONE, YOU ARE NOT COVERED BY WORKERS' COMP. INJURIES THAT OCCUR AT WORK CANNOT BE BILLED TO YOUR REGULAR INSURANCE. IN THAT CASE, YOU WILL BE RESPONSIBLE FOR ALL MEDICAL BILLS).

DID YOU SEEK EMERGENCY TREATMENT? YES NO

IF YES, WHERE? ____

ARE YOU PRESENTLY WORKING? YES NO DATE RETURNED: ____________

IS THE WORK REGULAR DUTY? YES NO LIGHT WORK? YES NO