CONFIDENTIAL PATIENT QUESTIONAIRE

REFERRED BY:_____ **ACCT.#**_____

LAST NAME_____ FIRST NAME _____ MI_____

ADDRESS _____ CITY _____ .STATE_____ ZIP_____

HOME(_____)_____ WORK(_____)_____ CELL (_____)_____

AGE_____ DATE OF BIRTH_____/_____/_____ SEX ☐ M ☐ F SOC .SEC.# _____–_____–_____

MARITAL STATUS ☐ S ☐ M ☐ D ☐ W SPOUSE'S NAME_____

PRIMARY CARE PHYSICIAN: _____ TEL. (_____) _____

ADDRESS: _____

EMPLOYER INFORMATION

EMPLOYER NAME:_____ OCCUPATION_____

ADDRESS: _____ TEL.(_____) _____- _____

_____ FAX.(_____) _____ - _____

INSURANCE INFORMATION

INSURANCE NAME:_____ TEL. (_____) _____-_____

ADDRESS: _____ POLICY#_____

_____ WCB#G-_____ CLAIM#_____

AUTO INJURY/WORK INJURY/PERSONAL INFORMATION

CASE TYPE: ☐AUTO ☐WORK ☐LIEN/SLIP & FALL ☐ PRIVATE INSURANCE

DATE OF INJURY _____

DESCRIBE HOW INJURY OCCURRED?_____

WHICH BODY PART/S WERE INJURED?_____

DID YOU REPORT THE INJURY ☐ NO ☐YES, TO WHOM _____

DID YOU GO TO THE HOSPITAL? ☐NO ☐YES NAME OF HOSPITAL_____

IF YES, WERE YOU TAKEN BY AMBULANCE? ☐NO ☐YES

WAS MEDICATION PRESCRIBED? ☐NO ☐YES

X-RAYS TAKEN? ☐NO ☐YES

WERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐NO ☐ YES

ARE YOU PRESENTLY WORKING? ☐NO ☐ YES, IF NO DATES LOST FROM WORK _____

IF AUTO INJURY, WERE YOU? ☐DRIVER ☐PASSENGER ☐PEDESTRIAN

#OF PEOPLE IN YOUR VEHICLE? _____ WORE SEAT BELT? ☐NO ☐YES, DID AIRBAG INFLATE ☐NO ☐ YES

ATTORNEY INFORMATION

NAME: _____ TEL. (_____) _____-_____

ADDRESS: _____ Fax. (_____) _____ -_____

PATIENT HISTORY OF PRESENT ILLNESS

Chief complaints/Injured sites:_____

Where is the pain/problem? Does it travel to other areas? _____

What caused the pain? Was there a specific injury? _____

Describe the pain (Dull, throbbing, sharp?)_____ How severe is the pain (scale 1-10)_____
(with 10 most severe)

How long have you had this pain/problem? When did it start? _____

When does the pain/problem occurs (after exercise, at night etc),_____

Is the pain constant or intermittent? _____ How frequent is the pain/problem?_____

What other associated problems are you having _____
(Numbness, swelling, cracking, popping, grinding, locking, etc)

What makes the problem better? _____ What makes the problem worse?_____
(Rest, ice, medications) (work, athletics, specific activity)

Have you seen any other physicians for this problem prior to coming to our office? ☐Yes ☐No

If yes, please list 1._____ when? _____

2._____ when? _____

Were x-rays, MRI, CT scan, or EMG tests performed?_____ when? _____

What treatment, if any, have you received for this condition? (please check all that apply)

☐Physical therapy ☐Chiropractic ☐Acupuncture ☐Surgery ☐Injections ☐Medication

Did the treatment help?_____ For how long?_____ Other _____

PAST HISTORY OF PRESENT ILLNESS

Have you previously experienced same or similar symptoms ? ☐Yes ☐No

What type of treatment/s did you received? _____

Did the treatment resolved your symptoms? _____

PATIENT'S PAST MEDICAL HISTORY

Patient Name _____ Height: _____'_____ Weight: _____lbs

Chief complaints:_____

Have you had any of the following? Please check all that apply.

☐Aids or HIV+	☐Diabetes	☐Low blood pressure	☐Smallpox
☐Anemia	☐Diphtheria	☐Measles	☐Stroke
☐Arthritis	☐Epilepsy/Seizures	☐Migraine Headaches	☐Thyroid Disease
☐Asthma	☐Glaucoma	☐Mitral Valve prolapse	☐Ulcer
☐Back trouble	☐Heart Disease	☐Mumps	☐Venereal Disease
☐Bladder infections	☐Hemorrhoids	☐Pneumonia	☐Whooping cough
☐Blood transfusions	☐Hight blood pressure	☐Polio	☐Other _____

MEDICATIONS (please include non-prescriptions and Herbal Supplements)

Drug name	Dosage	Frequency	Drug name	Dosage	Frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		

ALLERGIES

Medication	Reaction	Medication	Reaction
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Tape Allergy ☐Yes ☐No Latex Allergy ☐Yes ☐No

PAST SURGICAL HISTORY

Please list previous hospitalizations/surgeries/serious illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE ANY METAL IN YOUR BODY ☐Yes ☐No

What kind of metal/screws?_____

WORK HISTORY

Current occupation _____ Employer _____ Length of employment _____

Work status ☐Full Duty ☐Light Duty ☐Not working/list reason_____

Physical work duties (please check all that apply)

☐Lift ☐Walk ☐Stand ☐Carry ☐Kneel ☐Climb ☐Type ☐Write ☐Site ☐computer use

Other work duties not listed above _____

HOBBIES/SPORTS What type of hobbies/sports do you play? (please check all that apply)

☐Running ☐Weightlifting ☐Tennis ☐Bicycling ☐Aerobics ☐Swimming, ☐Skiing

☐Softball ☐Racquetball ☐Other _____

REVIEW OF SYMPTOMS **Have you experienced any of the following signs or symptoms listed below**

Musculoskeletal

Joint pain	___Yes	___No
joint stiffness or swelling	___Yes	___No
Weakness of muscles or joint	___Yes	___No
Muscle pain or cramps	___Yes	___No
Back pain	___Yes	___No
Cold extremities	___Yes	___No
Difficulty Walking	___Yes	___No

Constitutional Symptoms

Bad general health lately	___Yes	___No
Recent weight change	___Yes	___No
Fever	___Yes	___No
Fatigue	___Yes	___No
Headaches	___Yes	___No

Ear / Nose /Mouth /Throat

Hearing loss or ringing	___Yes	___No
Earaches or drainage	___Yes	___No
Chronic sinus problem	___Yes	___No
Nose bleeds	___Yes	___No
Bleeding gums	___Yes	___No
Sore throat /voice change	___Yes	___No
Swollen glands in neck	___Yes	___No

Cardi

Cardiovascular		
Heart trouble	___Yes	___No
Chest pain angina pectoris	___Yes	___No
Palpitation	___Yes	___No
Shortness of breath	___Yes	___No
While walking	___Yes	___No
Swelling of feet / ankles/hands	___Yes	___No

Genitourinary

Frequent urination	___Yes	__No
Burning or painful urine	___Yes	__No
Blood in urine	___Yes	__No
Incontinence or drilling	___Yes	__No
Female-number of pregnancies	_____	
Female-number of deliveries	_____	

Integumentary (Skin, breast)

Rash or itching	___Yes	__No
Changes in skin color	___Yes	__No
Varicose veins	___Yes	__No
Breast pain	___Yes	__No
Breast lump	___Yes	__No

Neurological

Light headed or dizzy	___Yes	__No
Numbness or tingling	___Yes	__No
Tremors	___Yes	__No
Paralysis	___Yes	__No

Endocrine

Excessive thirst or urination	___Yes	__No
Heat or cold intolerance	___Yes	__No
Skin becoming dryer	___Yes	__No
Hematologic/Lymphatic	___Yes	__No
Slow to heal after cuts	___Yes	__No
Bleeding or bruising tendency	___Yes	__No
Anemia	___Yes	__No
Enlarged glands	___Yes	__No

Psychiatric

Memory loss or confusion	___Yes	___No
Nervousness	___Yes	___No
Depression	___Yes	___No
Insomnia	___Yes	___No

Gastrointestinal

Los of appetite	___Yes	___No
Nausea or vomiting	___Yes	___No
Frequent Diarrhea	___Yes	___ No
Constipation	___Yes	___No
Rectal bleeding/blood	___Yes	___No
Abdominal pain	___Yes	___No

Respiratory

Chronic or frequent coughs	___Yes	___No
Spitting up blood	___Yes	___No
Shortness of breath	___Yes	___No
Wheezing	___Yes	___No

Eyes

Eyes disease or injury	___Yes	___No
Wear glasses/contact lenses	___Yes	___No
Blurred double vision	___Yes	___No

Allergies/immunologic

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorized the health care provider staff to perfume the necessary services I may need.

Patient's signature or parent of minor X_____ Date_____

PATIENT SOCIAL HISTORY

Marital status	Use of alcohol	Use of Tobacco	Living situation	Dominant hand
☐Single	☐Never	☐Never	☐With Family	☐Right
☐Married	☐Rarely	☐Previously, but quit	☐With Friends	☐Left
☐Divorced	☐Moderate	☐Currently	☐Alone	
☐Widowed	☐Daily	☐_____Packs per day	☐Other_____	

PATIENT FAMILY HISTORY

	Age	Condition or Diseases	If Diseased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorized the health care provider staff to perfume the necessary services I may need.

Patient's signature or parent of minor X_____ Date_____

INFORMED CONSENT

I have received information about my condition and proposed Chiropractic Rehab as well as alternative courses of treatment along with associated risks, benefits and side effects of the treatment and consequences of not having the proposed treatment.

I understand that I am informed that, as in all Health Care, in the practice of spinal manipulation there are some risks to treatments, including but not limited to muscle strains, fractures, dislocation, disc injuries, and vascular accidents.

My doctor has responded to all my requests for information about the proposed treatment. I have read or have read to me, the above consent. I have also had the opportunity to ask questions about this consent. By signing below, I consent to Chiropractic Rebah.

Name _____ Signature X_____

Witness by _____ Date _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
MAXIMUM ORTHOPEDICS - 369 E. 149TH STREET-9TH FLOOR, BRONX, NY 10455

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) **PRESENT**

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: **Please include all triage records**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**ONE YEAR**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

AUTHORIZATION FOR EMAIL CORRESPONDENCE AND TEXT MESSAGES

Date _____

My preferred language to be contacted in is: ☐ English ☐ Spanish

☐ Please check this box to receive emails and text messages from Maximum Orthopedics.

I _____, authorize Maximum Orthopedics to send me email correspondence
(Print your name)

and text messages pertaining but not limited to, appointment reminders, courtesy emails, and follow-ups.
I understand that I am going to receive emails and text messages, and this is an acknowledgement to my agreement.

Email : _____ Cellphone number: _____

Signature X_____

☐ Please check here if you do not want to receive emails or text messages from Maximum Orthopedics.

AUTORIZACIÓN PARA CORRESPONDENCIA POR CORREO ELECTRONICO Y MENSAJES DE TEXTO

Date _____

Mi idioma de preferencia para ser contactado/a es: ☐ Inglés ☐ Español

☐ Porfavor indique aqui si deseas receibir mensajes y correos electronicos de parte de Maximum Orthopedics.

Yo _____, autorizo que Maximum Orthopedics
(Nombre en letra de molde)

me mande mensajes pertenientes per no limitados a, recuerdos de cita, cortesia y seguimientos.

Yo entiendo que yo voy a ser contactado/a por estos medios y esto es reconocimiento de mi acuerdo

Correo electronico: _____ Numbero de cellular: _____

Firma X_____

☐ Porfavor indique aqui si no deseas receiver correos electronicos y mensajes de texto de parte de Maximum Orthopedics.

NEW YORK STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to DR. TYORKIN, DR. CIANCIMINO, DR. FENIG, DR. DAWSON, BESTCARE PT & CHIRO,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at CENTURY CENTRAL CHIRO, CITYCARE CHIRO - 369 E. 149TH STREET - 9TH FLOOR, BRONX, NY 10455.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

X _____ _____
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

NEW YORK STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

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Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

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Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to DR. TYORKIN, DR. CIANCIMINO, DR. FENIG, DR. DAWSON, BESTCARE PT & CHIRO,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at CENTURY CENTRAL CHIRO, CITYCARE CHIRO - 369 E. 149TH STREET - 9TH FLOOR, BRONX, NY 10455.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

X _____ _____
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address MAXIMUM ORTHOPEDICS 369 E. 149TH STREET-9TH FL BRONX, NY 10455

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-____ 5. Phone Number: (____)_____ 6. Gender: ☐ M ☐ F ☐ X

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

_____

_____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

_____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

_____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

_____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

_____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

_____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

_____

_____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

_____

_____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if they are legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____