

WORKER COMPENSATION INFORMATION

The Glen Chiropractic & Acupuncture

Patient Information

Name: _____ Birthdate: _____ Social Security # _____
Address: _____
Home Phone: (____) _____ E-mail: _____
Cell Phone: (____) _____ Occupation: _____

Employer

Employer Name: _____
Employer Address: _____
Employer Phone: (____) _____ Injury Verified by (For Office Use Only) _____
Contact Person: _____ E-mail: _____

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier: _____
Carrier Address: _____
Carrier Phone: (____) _____ Coverage Verified by: _____
Adjuster's Name: _____ Claim Number: _____

Injury Information

Date of Injury: _____ Time: _____ AM PM Place of Injury: _____
Accident reported to employer? Yes No Name of Person you reported accident to: _____
Give full description of how accident happened: _____

Have you lost time from work? Yes No How much? _____
Other doctors seen for this condition: Doctor's Name _____
Diagnosis: _____ Were X-Rays taken? Yes No Other tests? Yes No
If yes, by whom? Please list test(s) and result(s) _____

Any previous Worker Compensation injuries? Yes No Date(s) of previous injuries: _____
Describe previous Worker Compensation injuries: _____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative: _____ Date: _____

Please Print Name: _____ Relationship to Patient: _____