

WORKERS' COMP – WORK RELATED INJURY INFORMATION

Please answer every question.

Name _____ SS# _____ D.O.B. _____

Address _____ Phone (H) _____ (W) _____

Date of Accident _____ Did you file an Accident Report with your Employer? Yes No

Area of Concern _____

Describe briefly how the injury occurred/include which body areas are involved _____

Employer's Name _____

Address _____

Phone _____ Contact Person _____

Workers' Compensation (WCB) Case # _____

Insurance Company _____ Address _____

Phone _____

Contact Person _____ Insurance Company Carrier Case # _____

Hospitalized? Yes No Name of Hospital _____

X-rays taken? Yes No Date _____ Location _____

Other Doctors seen _____

Are you working now? Yes No

Time lost from work: from _____ to _____ (dates)

Present work restrictions _____

Do you have an attorney who has advised you in this claim? Yes No

Attorney's name _____ Phone _____

Address _____

Patient Signature _____

Date _____