

WORKERS COMPENSATION REGISTRATION FORM

DATE: _____

PATIENT NAME _____

ADDRESS _____ CITY _____ ZIP _____

PHONE _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ SEX M () F ()

EMPLOYER NAME _____

ADDRESS _____ CITY _____ ZIP _____

EMPLOYER PHONE _____ CONTACT PERSON _____

WORKERS COMP INS CARRIER _____

ADDRESS _____ CITY _____ ZIP _____

CARRIER CASE# _____ WCB# _____

DATE OF INJURY _____ WHAT TOWN DID INJURY OCCUR? _____

HOW DID INJURY OCCUR? _____

WAS ACCIDENT REPORTED AT WORK? YES NO

WAS AN ACCIDENT REPORT FILED WITH WORKERS COMP INS CARRIER?

YES NO

(IF THE ABOVE IS 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 WOULD BE RESPONSIBLE FOR ALL BILLS.)

DID YOU SEEK EMERGENCY TREATMENT? YES NO

IF YES, WHERE? _____

ARE YOU PRESENTLY WORKING? YES NO // DATE RETURNED _____

REGULAR DUTY? YES NO

LIGHT WORK? YES NO