WORKER'S COMPENSATION INTAKE FORM

Phone (302) 355-0900
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WORKER'S COMPENSATION INFORMATION

Patient's Name: Date of Birth:

PLEASE PROVIDE THE FOLLOWING INFORMATION (COMPLETE FOR INITIAL VISIT ONLY):

Employer:

Address:

Phone #: Supervisor:

Worker's Compensation Insurance Carrier:

Address:

Claim Number: Adjustor Name:

Adjustor Phone #: Date and State of Accident:

PROVIDE A BRIEF DESCRIPTION OF THE ACCIDENT AND INJURIES (COMPLETE FOR INITIAL VISIT ONLY):

ATTORNEY'S INFORMATION (IF APPLICABLE & COMPLETE FOR INITIAL VISIT ONLY):

Attorney's Name:

Attorney's Phone Number:

CURRENT WORK STATUS (COMPLETE FOR ALL VISITS)

Current Work Status: Date:

In the event my claims are denied from the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable.

I understand that I am responsible for any payment of all services rendered should my claims be denied.

Signature: **X** Date: