Worker Compensation Information

Shiloh Pain and Primary Care

Patient Information

Name:________________________ DOB: ____________ Last 4 of SSN: ____________

Worker Compensation Information

Employer Name: ________________________________

Address: ______________________

City: ____________________ State: ____ Zip: __________

Contact Person: __________________ Phone: ______________________

Carrier Name: ____

Address to submit claim: ____

City: ____________________ State: ____ Zip: ______________

Adjuster Name: ____________________________ Adjuster Ph: ____________________

Claim #: ___________________________ Date of Injury: ______________

Injury Information

Place of Injury: _________________________________

Was accident reported to employer? Yes / No Name of person reported to: ____________________

Give full description of how accident happened: ____

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Have you lost time from work? Yes / No If so, how much time? ________

Any previous worker compensation injuries? Yes / No Dates: ______________________

If so, describe previous worker compensation injuries: ______________________________

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Lawyer Information

Have you retained an attorney? YES / NO. If yes, please complete the following information:

Attorney Name: ____

Address: ____

City: ____________________, State: _____ Zip Code: __________

Phone: __________________ Fax: ____________________

Letter of Protection Requested: ________

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 (or Parent/Legal Guardian/ Personal Representative) *Date*

____ ____________________

Print name of Patient (or Parent/Legal Guardian/ Personal Representative) *Relationship to Patient*