Place Patient Label Here

Workers' Compensation Form

Appointment Information

Appointment Date: ______ **Patient to see Dr.:** ______________ **Referred by Dr.:** ______________

Reason for Today's Visit:

Employee Information

Employee Name: ____

Last *First* *M.I.*

SSN: ______________

Birth Date: ______________ **Address:** ______________________________

____

Employer Information

Employer Name: ______________________ **Contact:** ______________________

Phone: ______________________ **Fax:** ______________________

Address: ____

Authorization to Communicate with Employer: *I hereby authorize Associated Physicians to communicate with my employer regarding this this injury for purposes of payment. I understand that this may include sharing information regarding service obtained at the clinic.*

Please check one box below.

[Yes] Yes, you may share information to facilitate payment

[No] No, you may not share any information. I will provide all information directly and accept any ultimate financial responsibility if I am unable to provide the information in a timely fashion.

Accident Insurance Carrier Info:

Insurance Name: ______________________ **Claim Number:** ______________________

Adjustor Name: ______________________ **Case Manager Name:** ______________________

Phone: ______________________ **Phone:** ______________________

Carrier Address: ______________________ **Fax:** ______________________

______________________ **Date of Injury:** ______________________

Injury Sustained:

Dates Missed Work: From: To:

Signatures

Employee Signature: ____________________________________ **Date:** ______________

For Physical Therapy appointments, please provide a copy of your job description so we can better treat your needs.