WORKERS COMPENSATION QUESTIONNAIRE

Today's Date ______________________

Patient's Name ______________________

Patient's Address ____

____

Phone Number (Home/Cell) ______________________

Date of Injury ______________________

Place of Injury (city, town or village) ____

Employer Name ____

Employer Address ____

Employer Phone (____)______________________ Fax (______)______________________

Contact Person ______________________ Title ______________________

Employer Insurance Carrier ______________________

Insurance Carrier Address ____

Insurance Carrier Phone (____)______________________ Fax (______)______________________

Insurance Carrier Contact Person ______________________ Ext ____________

Workers Comp Case # ______________________ Insurance Carrier # ______________________

Please describe how injury occurred. Patient states, "While at work, I ______________________

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Did you report your accident to your employer? ☐ YES ☐ NO

When did your symptoms appear? ______________________

Are you presently working? ☐ YES ☐ NO

Were you hospitalized for this injury? ☐ YES ☐ NO

Have you seen other doctors for this condition? ☐ YES ☐ NO

Were X-rays taken? ☐ YES ☐ NO

Have you lost time from work? ☐ YES ☐ NO

If yes, what are the exact dates of lost time from work: ______________________

Any previous Workers Compensation injuries? ☐ YES ☐ NO

If yes, please provide us with previous injuries and dates: ______________________

Patient's Signature ______________________ Date ______________________

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I ______________________________ understand that if the judge rules against the
(Patient Name printed)

causal relationship arising out of and in the course of my employment, I will be held responsible for my outstanding account balance. I understand that every attempt will be made on my behalf to bill my private insurance company, if the judge rules against my ____________________
(Date of Injury)
work related injury.

______________________________ ____________________
(Patient Signature) (Date)