WORKERS' COMPENSATION INTRODUCTION FORM

Patient Name:	Today's Date:
Address:	Home Telephone:
City/State/Zip:	Work Telephone:
Date Birth: Age:	Employer's Name:
Height: Weight:	Employer's Address:
Social Security No:	Job Title:
Drivers License No:	Marital Status (Circle): Single, Married, Divorced, Widowed

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

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Date of Injury:	Date: Time:
Location of Injury:	
Employer at Time of Injury:	
Address of Employer:	
Job Title at Time of Injury:	
Length of Time Employed:	
Name of Current Employer:	

DESCRIBE HOW INJURY HAPPENED: ______________________________________

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☐ YES, ☐ NO Have you notified your employer about your injury?
☐ YES, ☐ NO Has your employer notified their workers comp insurance carrier?
☐ YES, ☐ NO Have you filled out an injured workers' claim form?
☐ YES, ☐ NO Do you have an attorney representing you for this work related injury?

WORKERS' COMPENSATION INSURANCE INFORMATION

Name of Insurance Carrier:	
Address of Insurance Carrier:	
Claim Adjusters Name:	
Claim Adjuster's Telephone Number:	
Claim Number:	

WERE YOU UNABLE TO WORK AFTER THE WORK RELATED INJURY?

☐ YES, ☐ NO If yes, you were off work on the following dates: ______________ to ______________.
Indicate how many full days off work: _______ days. Indicate how many partial days off work: ______ days.

Indicate your work status at the present time:

☐ Full Disability, ☐ Partial Disability, ☐ Part Time Work, ☐ Full Time Work