Worker Compensation Information

Dr. Michael P. Smith, DC
Rock County Chiropractic
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(507) 283-2561 PH (507) 283-1831 FAX

Name _____ Birthdate _____ Soc Sec # _____-____-_____

Address _____Telephone (_____) _____-_____

Occupation _____

EMPLOYER

Employer Name _____

Employer Address _____

Employer Telephone (____) ____-_____ Injury Reported To (FOR OFFICE USE) _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____

Carrier Telephone (____) ____-_____ Coverage Verified by _____

Adjuster's Name ____ _____ Claim Number _____

INJURY INFORMATION

Date of Injury ____/____/____ Time _____ a.m. / p.m. Place of Injury _____

_____ Accident Reported to Employer? Yes / No

Name of person you reported accident to _____

Give a FULL description of how accident happened _____

_____ .

Have you lost time from work? Yes / No How Much? _____

Have you seen anyone else for this injury? Yes / No Doctor's Name _____ _____ DC / MD / other

Diagnosis _____ Were X-rays taken ? Yes / No Were other tests performed? Yes / No

Please list those tests and results _____

Any other Worker Compensation injuries? Yes / No Dates of previous injuries _____

Describe previous Worker Compensation injuries _____

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.

Patient's Signature _____ Date _____/_____/_____