# WORKER COMPENSATION INFORMATION

Riverview Spine: Health and Injury Care

## Patient Information

Name:_____ Birthdate:_____ Social Security #_____

Address:_____

Home Phone: (____) _____ E-mail:_____

Cell Phone: (____) _____ Occupation:_____

## Employer

Employer Name:_____

Employer Address:_____

Employer Phone: (____) _____ Injury Verified by (For Office Use Only) _____

Contact Person:_____ E-mail:_____

## Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier:_____

Carrier Address:_____

Carrier Phone: (____) _____ Coverage Verified by:_____

Adjuster's Name:_____ Claim Number:_____

## Injury Information

Date of Injury:_____ Time:_____ ❑ AM ❑ PM Place of Injury:_____

Accident reported to employer? ❑ Yes ❑ No Name of Person you reported accident to:_____

Give full description of how accident happened:_____

_____

_____

Have you lost time from work? ❑ Yes ❑ No How much?_____

Other doctors seen for this condition: Doctor's Name_____

Diagnosis:_____ Were X-Rays taken? ❑ Yes ❑ No Other tests? ❑ Yes ❑ No

If yes, by whom? Please list test(s) and result(s) _____

_____

_____

Any previous Worker Compensation injuries? ❑ Yes ❑ No Date(s) 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. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative:_____ Date:_____

Please Print Name:_____ Relationship to Patient:_____