WORK COMPENSATION INFORMATION

Lyon County Chiropractic

Dr. Cody Hoefert, DC Dr. Nick Weber, DC

909 S. Union St.

Rock Rapids, IA 51246

712-472-4732

Name_____ Birthdate_____ Soc Sec # _____-_____-_____

Address_____Telephone (_____) _____-_____

Occupation_____

Employer

Employer Name_____

Employer Address_____

Employer Telephone (_____) _____-_____ Injury Reported to (FOR OFFICE USE) _____

Work 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 ____/____/____