WORKER'S COMPENSATION FORM

PATIENT MUST COMPLETE THIS FORM IF THEY ARE RECEIVING TREATMENT AS A RESULT OF AN INJURY SUSTAINED IN THEIR PLACE OF EMPLOYMENT OR BUSINESS

PATIENT NAME:_____

PATIENT ADDRESS:_____

CITY/STATE/ZIP:_____

PATIENT PHONE:_____PATIENT SOCIAL SECURITY #:_____

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PLACE OF EMPLOYMENT/BUSINESS:_____

ADDRESS OF EMPLOYMENT/BUSINESS:_____

CITY/STATE/ZIP CODE:_____

BUSINESS PHONE:____(____)_____(____)_____
DAY EVENING

CONTACT PERSON & TITLE:_____

DATE & TIME OF INJURY_____

DESCRIBE INJURY:_____

**I UNDERSTAND THAT IF NO CONTACT CAN BE MADE WITH MY EMPLOYER/PLACE OF BUSINESS OR IF THERE IS REFUSAL TO COVER THE TREATMENT, I, WILL BE RESPONSIBLE FOR PAYMENT TONIGHT. I ALSO AUTHORIZE: RELEASE OF INFORMATION TO MY EMPLOYER REGARDING THIS INJURY AND THE BILLING OF THIS INJURY TO EMPLOYER/WORK COMP CARRIER.

_____ _____
SIGNATURE OF PATIENT DATE

TO BE COMPLETED BY MEDPLUS STAFF

NAME TITLE OF CONTACT PERSON:_____

DATE/TIME OF CONTACT:_____

COMPLETE BILLING ADDRESS:_____

CITY/STATE/ZIP:_____

MEDPLUS PERSONNEL:_____