WORKER'S COMPENSATION INFORMATION

The information given here directly affects your Worker's Compensation Claim. PLEASE make sure ALL information is complete and accurate.

Patient Name: ______________________________ **Date of Birth:** ______________________________
Address: ____
City/State: _________________________________ **Zip Code:** _________________________________
Phone Number: ____________________ **Social Security #:** ____________________________________

Employer: ____
Address: ____
City/State: _________________________________ **Zip Code:** _________________________________
Phone Number: ________________ **Contact Person:** _______________________________________
Have you filed a report with your employer? ____
At the time of injury what was your job title? ____
What are your usual work activities? ____
____

Worker's Compensation Carrier: ____
Address: ____
City/State: _________________________________ **Zip Code:** _________________________________
Phone Number: ___________________ **Contact Person:** ____________________________________
WC Case Number: ____________________ **Carrier Case Number:** _____________________________

Address Where Injury Occurred: ____
City/State: _________________________________ **Zip Code:** _________________________________
Describe how the injury occurred ____
____
____
____

Date of Injury: _________ **I worked that day:** _____ **All Day** ______ **Part Day**
Are you currently working? ____
Have you been off of work due to the injury? ____
If YES, First day off due to injury: ____
If NO, when was your return to work date? ____

Have you ever had the same injury or similar injury? ________ **Yes** _______ **No**
If "Yes", date(s) of previous injury ____
Have you been treated by another doctor for this injury? _______ **Yes** ________ **No**
If "Yes" who was the doctor ____
Is an attorney or a licensed representative representing you? ________ **Yes** _______ **No**
If "Yes", name, address, phone #, fax# of representative _______________________________________
____

(OVER-NEED Patient Signature on reverse side)

TO MY KNOWLEDGE ALL THE ABOVE INFORMATION IS CORRECT

I authorize benefits to be paid directly to the provider of medical services at Alden Medical Group.

I authorize Alden Medical Group to furnish all information they may have regarding my condition while under observation or treatment, including the history obtained, x-rays and physical findings, diagnosis and prognosis to the Worker's Compensation Insurance Carrier. The physician treating me is authorized to provide this information in accordance with the Worker Compensation Laws.

SIGNATURE: ______________________________ DATE: __________________