WORKERS COMPENSATION INSURANCE INFORMATION

Patient Name: _____ Social Security #: _____

WCB #: _____

Carrier Case#: _____

Date of Injury: _____/ _____/_____

Occupation on date of injury: _____

Job duties on date of injury: _____

Is patient currently working? Yes_____ No _____. If no, last date worked: _____

Employer Name on date of injury: _____

Employer Address on date of injury: _____

Employer phone on date of injury: _____

Insurance Company Name: _____

Insurance Company Address: _____

Adjuster Name: _____

Adjuster Phone Number: _____

Adjuster Fax Number: _____

Attorney Name: _____

Attorney Phone Number: _____

Attorney Fax Number: _____

Describe Accident:

_____

_____

_____

_____

What body part(s) did you report at the time of the accident?

_____

_____