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WORKER'S COMPENSATION / ON THE JOB ACCIDENT/INJURY

PATIENT NAME: _____
SSN: _____
EMPLOYER: _____
DATE OF INJURY: _____
ADDRESS OF EMPLOYER: _____
PHONE NUMBER OF EMPLOYER: _____
SUPERVISOR: _____

Was the injury reported at work? NO YES
If yes, to whom? _____

Work Comp Insurance Company: _____

Work Comp Address: _____

Work Comp Phone Number: _____

Claim # _____

Adjustor Name: _____

I understand that if the Worker's Comp Carrier or Employer do not pay on this the claim, I am responsible to pay for the service rendered.

Signature: _____ Date: _____

I authorize the release of any medical information necessary to process this claim.

Signature: _____ Date: _____