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#15 Northport Plaza
Hannibal, MO 63401
573-221-2001

WORK COMPENSATION

Date: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ SSN: _____
Address: _____
Telephone: _____ Occupation: _____

EMPLOYER

Employer's Name: _____
Employer's Address: _____
Employer's Telephone: _____ Injury Verified By (Office Use Only) _____
Contact Person: _____

WORKER'S COMPENSATION INSURANCE INFORMATION

(It is illegal to bill both worker's compensation and major medical insurance for the same injury.)

Worker's Compensation Insurance: _____
Carrier Address: _____
Carrier Telephone: _____ Coverage Verified By (Office Use Only) _____
Adjuster's Name: _____ Claim #: _____

INJURY INFORMATION

Date of injury: _____ Time: _____ am/pm
Place of injury: _____
Accident reported to employer? _____ yes _____ no
Name of person you reported accident to: _____
Do we have permission from your employer to treat you? _____ yes _____ no

Give a full description of how the accident occurred: _____

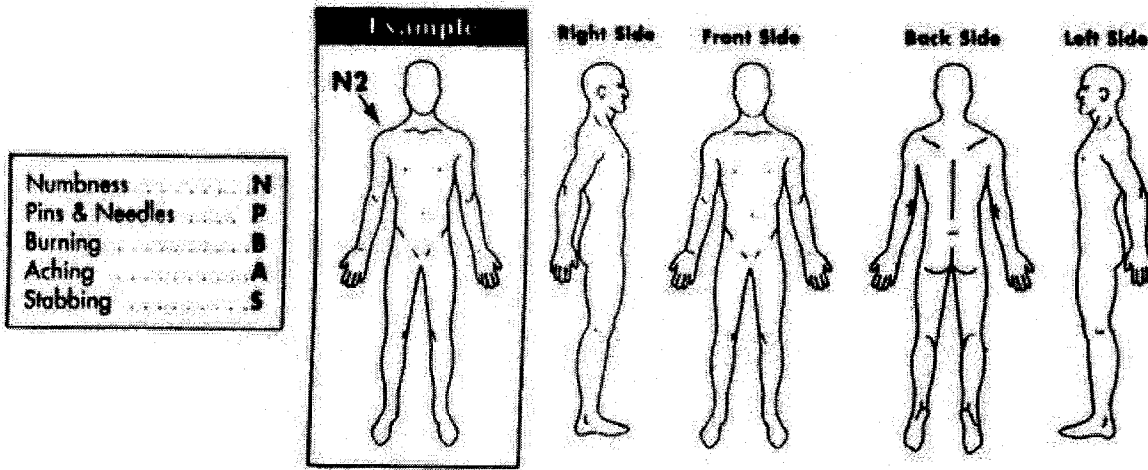
Where are you hurting? _____ head _____ neck _____ arms _____ feet _____ shoulder _____ hands (l/r)
_____ upper back _____ mid back _____ low back _____ right side _____ left side _____ legs

How did you hurt yourself? _____ lifting _____ twisting _____ tripped _____ fell _____ carrying _____ bending
_____ A.A. _____ slipped _____ other _____

Did any weather conditions play a part in your hurting yourself? _____ yes _____ no
If so, _____ slippery condition _____ ice _____ snow _____ rain _____ sunlight _____ water
Please explain: _____

Did you land on a hard soft surface?
 Did you feel pain immediately later?
 If later, how long after the accident did you feel the pain? minutes hours days
 Is the pain worse same better since accident?
 Have you had trouble in this area before? yes no
 If yes, have you been feeling good up until this time? yes no
 If no, is the pain worse same better?

Mark an X on the picture where you continue to have pain, numbness, or tingling. Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain).



Have you lost time from work? yes no How much time?

Other doctors seen for this condition:

Doctor's name: Diagnosis:

Were x-rays taken? yes no Other tests? yes no

If yes, by whom? Please list test(s) and result(s):

Any previous 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 Workers Compensation benefits is denied. **I have received permission from my company to receive care in your office yes no.**

Patient's signature: Date: