Workers Compensation Information

(Please provide your photo ID)

Patient Information:

Last Name: _____ First Name: _____ Middle Name: _____

D.O.B: _____ /_____ /_____ Gender: __Male __ Female Social Security #: _____-_____-_____ Language: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____ Email address: _____

Emergency Contact Name: _____ Relationship: _____ Phone #:(_____) _____-_____

Address: _____ City: _____ State: _____Zip: _____

Work Information (at the time of injury):

Company Name: _____ Tittle: _____ Supervisor: _____

Address: _____City: _____State: _____Zip: _____

Work Phone: (_____) _____-_____ Fax: (_____) _____-_____ Email:_____

On the date of injury/illness what was the patient's job duties: _____

_____

Description of the accident/Injury: _____

_____

Are you currently working? ___ No ___ Yes Where? _____ Date Last Worked? ____ /____ /_____

Workers' Compensation Carrier Information:

Date of Injury: _____ /_____ /_____ Insurance ID #: _____ WCB #: _____

Carrier Name: _____ Phone #:(_____) _____-_____ Fax: (_____) _____-_____

Address: _____ City: _____ State: _____Zip: _____

Adjuster Name: _____ Phone#: (_____) _____-_____ Fax #: (_____) _____-_____

Attorney Name: _____ Law Firm: _____ Phone#: (_____) _____-_____

Information Disclosure Authorization

I authorize Community Medical Wellness P.C. to obtain / release all medical records for treatment rendered pertaining to my work-related injury. I authorize payment of medical benefits to Community Medical Wellness P.C.

_____ _____ _____

Print Name Signature Date