



WORKERS' COMPENSATION INFORMATION

GENERAL INFORMATION:

Patient's Name: _____ Sex: ____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ SS#: _____
Marital Status: _____ Referring Physician: _____

INSURANCE INFORMATION: Have you reported your injury to your employer? Yes No (circle one)

Workers' Comp Insurance Carrier: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
WCB #: _____ Carrier Case#: _____
Employer Name: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Contact Person: _____ Phone: (____) _____

INJURY INFORMATION:

Date of Injury: _____ Time: _____
Were x-rays taken? Yes No (circle one) Where: _____ When: _____
Have you been treated by anyone else (including and Emergency Room)? Yes No (circle one)
Where?: _____
Briefly describe the accident and your injury.: _____

Address where accident occurred: _____ City: _____ State: _____ Zip: _____
Are you out of work? Yes No (circle one) Date last worked: _____

I authorize Community Care Physicians, PC to release all records pertaining to medical history, services rendered or treatment to me or my dependents for insurance claims. I authorize payment of medical benefits to Community Care Physicians, PC. I promise as guarantor for the above patient or as the patient to pay for all medical services deputed or denied by my insurance.

Patient's Signature

Date

TO BE COMPLETED BY RECEPTIONIST:

Name and title of Person Authorizing Treatment: _____
State authorization obtained: _____ By whom: _____ (initials)