Back to Health
CHIROPRACTIC
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WORKER COMPENSATION INFORMATION

PATIENT INFORMATION

Name:______________________________ Birthdate:_______ SSN#: _____ - _____ - ______

Address:____

Telephone: ____________________________Occupation:______________________________

EMPLOYER

Employer name: ____

Employer address: ____

Employer phone:_______________________ Contact person: __________________________

WORKER COMPENSATION CARRIER

Workers compensation carrier insurance:____

Carrier address: ____

Carrier phone number:__________________ Claim number:___________________________

Adjusters name:

INJURY INFORMATION

Date of injury:__________Time:__________Place of injury: __________________________

Accident reported to employer? ☐ yes ☐ no

Name of person you reported accident to: ____

Give full description of how accident happened:_____________________________________

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Have you lost time from work? ☐ yes ☐ no How much?_______ When? _____________

Was any other doctor seen for this injury? ☐ yes ☐ no

Doctors name:_________________________ Doctors phone:__________________________