WORKER'S COMPENSATION PATIENT FORM

TELL US ABOUT YOUR EMPLOYER

NAME OF EMPLOYER	EMPLOYER TELEPHONE #		
	( )		
EMPLOYER MAILING ADDRESS	CITY	STATE	ZIP CODE
NAME OF IMMEDIATE SUPERVISOR	IMMEDIATE SUPERVISOR'S TELEPHONE #		
	( )		

TELL US ABOUT THE INJURY

DATE OF INJURY	CAUSE OF INJURY
PLEASE TELL US ABOUT THE ACCIDENT AND INJURY	

TELL US ABOUT THE WORK COMP INSURANCE COMPANY

CLAIM NUMBER	CLAIM ADJUSTER'S NAME		
CLAIM ADJUSTER'S TELEPHONE #	CLAIM ADJUSTER'S FAX #		
( )	( )		
NAME OF WORK COMP INSURANCE COMPANY	WORK COMP INSURANCE COMPANY TELEPHONE #		
	( )		
CLAIMS MAILING ADDRESS	CITY	STATE	ZIP CODE

TELL US ABOUT YOUR MEDICAL CARE RELATING TO THIS INJURY

NAME OF TREATING PHYSICIAN	TREATING PHYSICIAN'S TELEPHONE #
	( )

PLEASE RETURN THIS FORM TO THE FRONT DESK RECEPTIONIST WHEN COMPLETED

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