



## WORKERS' COMPENSATION INTAKE FORM

### PATIENT & VISIT INFORMATION

Does the patient have authorization to be seen?  Yes  No

Visit Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

### EMPLOYER INFORMATION

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Human Resources Contact: \_\_\_\_\_

### DRUG SCREEN INFORMATION

Does the employer want a drug screen?  Yes  No

Who will be paying for the drug screen? Company Name: \_\_\_\_\_

Where should we send the results?

Email: \_\_\_\_\_  Fax: \_\_\_\_\_

Does the employer want to pay for this visit themselves?  Yes  No

***\*\*If the employer does NOT want to pay for the visit, please complete the section below\*\****

### WORKERS' COMP INSURANCE INFORMATION

WC Insurance Carrier: \_\_\_\_\_

Insurance Claim Number: \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_

Insurance Carrier Phone Number: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Adjuster Phone Number: \_\_\_\_\_

Adjuster Fax: \_\_\_\_\_