



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: _____