|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Delmarva%20Logo%20on%20Top%20(No%20Motto)%20copy%20black.png | **WORKER’S COMPENSATION INTAKE FORM** |

|  |  |  |
| --- | --- | --- |
|  | **Phone** | **(302) 355-0900** |
|  | **Fax** | **(302) 355-0901** |
|  | **Web** | delmarvapain.com |

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| --- |
| **WORKER’S COMPENSATION INFORMATION** |
| Patient’s Name:       | Date of Birth:       |
| **PLEASE PROVIDE THE FOLLOWING INFORMATION (COMPLETE FOR INITIAL VISIT ONLY):** |
| Employer:       |
| Address:       |
| Phone #:       | Supervisor:       |
| Worker’s Compensation Insurance Carrier:       |  |
| Address:       |  |
| Claim Number:       | Adjustor Name:       |
| Adjustor Phone #:       | Date and State of Accident:       |
|  |
| **PROVIDE A BRIEF DESCRIPTION OF THE ACCIDENT AND INJURIES (COMPLETE FOR INITIAL VISIT ONLY):** |
|       |
|       |
|       |
| **ATTORNEY’S INFORMATION (IF APPLICABLE & COMPLETE FOR INITIAL VISIT ONLY):** |
| Attorney’s Name:       |
| Attorney’s Phone Number:       |
|  |
| **CURRENT WORK STATUS (COMPLETE FOR ALL VISITS)** |
| Current Work Status:       |  Date:       |
| In the event my claims are denied from the above listed insurance carrier, I understand my personal health insurance will be billed. Therefore, for my protection, I will obtain the necessary referrals if applicable.I understand that I am responsible for any payment of all services rendered should my claims be denied. |
| Signature: **X**  |  Date:       |