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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: |