Workers Compensation Registration Form

WorkComp, Auto Accident or Personal Injury

(All information **MUST** be completed in order to bill your insurance company)

Patient Last Name_____First_____MI_____

Date of Birth_____Patient Social Security_____

Street Address_____Apt #_____

City_____State_____Zip_____-_____

Home Phone_____Work Phone_____

Marital Status (circle one) Married Single Divorced Widowed Separated

Sex (circle one) male female

Person to Notify in an Emergency_____

Phone_____

Referring Physician_____

Injury was a result of WORK ACCIDENT (circle one)

Describe Injury_____

Employer at the time of Injury_____

Insurance Company_____

Claim Number_____

Date of Injury_____

Adjustor's Name_____ Phone_____

Claim's Mailing Address_____Fax_____

City_____ Zip_____ State_____

Attorney's Name_____

Phone Number_____

I understand that I am liable for expenses incurred which are not covered under my plan. I understand that all co-payments, deductibles and/or non covered services are to paid in full at the time of service. I hereby authorize the release of any information to my insurance company necessary to process claims. I hereby authorize my insurance company to make payments directly to the physician. I authorize the release of medical records to attorneys involved in my case. I have read and agree to the policies and will abide by them.

Signed_____ Date_____

Print Name_____