WORKMEN'S COMPENSATION INFORMATION

PLUMSTEADVILLE FAMILY PRACTICE

PATIENT NAME: _____ SOCIAL SECURITY#: _____

HOME ADDRESS: _____

PRIMARY PHONE: _____ DATE OF BIRTH: _____

OCCUPATION/POSITION: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

SUPERVISOR: _____WORK PHONE#: _____

EMPLOYER'S INSURANCE COMPANY: _____

ADDRESS: _____

PHONE#: _____

CLAIM #: _____

DATE OF INJURY: _____ TIME OF INJURY: _____

PLACE OF INJURY: _____

BRIEF HISTORY OF INJURY: _____

_____

COMPLAINT: _____

Are you currently receiving treatment from another physician for this injury?

____ No ____Yes (Physician) _____

Have you ever been treated for this injury before? ___No ___Yes (Physician & Dates) _____

I hereby give authorization to release to my Employer or its designee any and all medical information and medical records which may be requested concerning my condition or the treatment of my work related injury or illness. I understand I will be held responsible for all bills incurred should this injury or illness be determined not to be work related.

EMPLOYEE SIGNATURE: _____ DATE: _____