FRANCIS CHIROPRACTIC CLINIC, S.C.

Worker Compensation Information

Date:_____

PATIENT INFORMATION

Name:_____Home Phone:_____Cell Phone:_____
Address:_____City:_____State:_____Zip:_____
Birth Date:_____Soc. Sec. #_____Occupation:_____
Patient Personal Insurance:_____Group (Plan) #:_____Policy/Subscriber ID #_____

EMPLOYER INFORMATION

Employer Name:_____Employer Telephone:_____
Employer Address:_____City:_____State:_____Zip:_____

INJURY INFORMATION

Date of Injury:_____Time:_____ ☐ AM ☐ PM
Place of Injury:_____
Accident reported to employer: ☐ Yes ☐ No Name of person you reported accident to:_____
Did they give authorization for treatment? ☐ Yes ☐ No
Give full description of how accident happened:_____
_____
_____
Have you lost time from work: ☐ Yes ☐ No
Other doctors seen for this condition:
Doctor's Name_____Location:_____
Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No
If yes, by whom? Please list test(s) and result(s)_____
_____
Did you receive post-injury hospitalization? ☐ Yes ☐ No How long?_____
List the extent of injuries as you know them:_____
_____
_____
Describe location and character of job:_____
How much do you lift?_____How often?_____

Check Symptoms You Have Noticed Since Injury:

☐ Headache	☐ Chest Pain	☐ Pins & needles in legs	☐ Ears ring
☐ Neck Pain	☐ Shoulder Pain	☐ Numbness in fingers	☐ Loss of balance
☐ Neck Stiffness	☐ Hip Pain	☐ Numbness in toes	☐ Dizziness
☐ Back Pain	☐ Pins & needles in arms	☐ Shortness of breath	☐ Other, specify_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to my Employer's Workers Compensation carrier, and that I am personally responsible for payment in the event that my claim for Workers Compensation is denied.

Patient's Signature:_____Date:_____

September 2013