



BUFFALO INTERVENTIONAL PAIN MANAGEMENT
550 Orchard Park Rd, Suite A104, Buffalo, NY 14224
734 Davison Road, Lockport, NY 14094
TEL: 716-203-1110 FAX: 716-217-6334

WORKERS COMPENSATION INTAKE FORM

Full Name: _____ Phone#: _____

E-mail : _____ Work#: _____
Cell#: _____

MailingAddress: _____

PhysicalAddress (If different from above): _____

How did you hear about us? _____

SS# _____ DOB: _____

Employer at Injury _____ Job Title _____

Job Duties _____

Length of employment prior to injury _____

Are you currently working? _____. If yes, Current Employer _____

ATTORNEY NAME: _____ TEL: _____

Date of Injury: _____ Adjuster: _____

W/C Insurance Company: _____ Phone#: _____

Fax# _____ CLAIM# : _____ WCB# _____

Is this Claim Apportioned? _____. If yes, Apportionment (%) _____

InsuranceAddress: _____

How were you injured? _____

What injuries did this accident cause? _____

Did you lose any time from work due to this injury? _____.

If yes, Date stopped working _____. When did you return to work (Date)? _____

Are you disabled at this time due to this injury? _____

If so, were you given a temporary or permanent disability rating? _____

If so, what is the percentage rating? _____

Doctors/Medical Providers who have treated you : _____

Prior Injuries- have you injured the same body part _____

Past Workers Compensation Claims? _____

Dates: _____

PAST EMPLOYMENT

Employer Name _____ Job Title _____

Employment Dates: _____ to _____

Job Duties _____
