Worker's Comp. Incident Form

Patient Name_____ Today's Date_____

Name of the Compensation Carrier_____

Name of the Employer:_____

The date of the work related injury was:_____

The time that the injury occurred was :_____ a.m./p.m

The last date worked was: (month)_____/ (day)_____/ (year)_____

Were you hospitalized?

- ❑ Yes – If yes, please answer the questions below.
- ❑ No

When were you hospitalized?

- ❑ Immediately
- ❑ Later the same day
- ❑ Next day
- ❑ Date _____

How were you transported to the Hospital?

- ❑ Ambulance
- ❑ Life Flight
- ❑ Private Transportation

What did the hospital recommend?

- ❑ See own Doctor
- ❑ See Orthopedist
- ❑ See neurologist
- ❑ Prescription medication
- ❑ See DC
- ❑ See this clinic
- ❑ No instructions
- ❑ Other: _____

Did you have x-rays taken?

- ❑ Yes
- ❑ No

If yes, in what area's?_____

My current job status is: (please mark the appropriate response below)

- ❑ Off work as a result of the injuries sustained in the reported work accident.

- ❑ Working full duty.
- ❑ Working light duty.

I:

- ❑ Have
- ❑ Have not

Been involved in previous work related accidents/injuries.

If you have been involved in previous work related accidents/injuries, please complete below.

Status of previous injuries:

- ❑ Treated and resolved
- ❑ Treated, unresolved, and located at an unrelated area to this accident
- ❑ Treated, unresolved, same area as current injury
- ❑ Not treated and a completely different area than current injury.
- ❑ Not treated and still have residual symptoms
- ❑ Not treated and do not have any residual symptoms

This accident was:

- Not reported to the employer.
- Reported to the employer.

The name of the employee it was reported to was: _____

Employee's Job Title:_____ Phone #: _____

How many hours did you work that same day prior to the accident? _____

Where did the injury occur? Location: _____

What type of work were you preforming at time of injury?_____

Describe the accident:_____
_____
_____
_____
_

I have:

- Been treated by another doctor for the injuries sustained in this accident.
- Not been treated by another doctor for the injuries sustained in this accident.

If you have been treated by another doctor, please continue with the following questions.

List the doctor's name and current/past
treatment:_____
_____
_____
_____

As a result of the treatment received thus far:

- ❑ My condition has improved
- ❑ My condition has not improved
- ❑ My condition has worsened since the injury despite treatment received thus far

Patients Claim Information

Is your condition due to:

- ❑ An auto accident
- ❑ Personal Injury
- ❑ Work. Comp. Injury

If Auto Accident/Personal Injury:

Who was found at fault/ticketed? Patient / Other driver

Responsible parties name: _____

Contact Info: _____

Responsible Party

Insurance company name: _____

Address:_____

Policy Number: _____

Claim Number: _____

Insurance Rep: _____

Phone: _____ Fax:_____

Attorney's Info

Lawyers Name: _____

Address: _____

Phone Number: _____

Contact Person: _____

If Workers Compensation:

Employer's Name: _____ Employer's Number _____

Employer's Address: _____

Are you currently employed at the same: _____

Has the injury been reported?

- ❑ Yes
- ❑ No

Has care been authorized?

- ❑ Yes
- ❑ No

By whom? _____

Employer's Insurance Carrier: _____

Address: _____

Policy Number: _____ Group Number: _____

W.C. Claim Number: _____

Authorizations

I Hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are arrangements between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____

Witness Signature: _____