

**WORKERS COMPENSATION INFORMATION AND LIABILITY
FORM**

Revised 01/08/08

Patient Name _____ Social Security No _____

Employer _____

Employer Address _____ City _____

State _____ Zip Code _____ Phone No _____

Complaint _____ Date of Injury _____

How did the injury occur _____

Have you reported your injury to your employer? _____

Name and position of person who took your injury report _____

Have you previously been treated for this injury? _____

What is your occupation? _____

Workers Compensation Insurance _____

Claim No _____ Adjuster _____

Adjuster Phone _____

I, _____, agree the above information is true and accurate. I understand that if treatment is not covered or further denied by workers compensation I will be responsible for payment of all charges incurred.

Patient Signature

Date

Witness

Date

