

# WORKERS COMPENSATION QUESTIONNAIRE

*Please fill out form completely. If something does not apply, put N/A.*

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Where did the injury occur? City/Town: \_\_\_\_\_ State: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Please describe the injury in your own words:

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Patient Phone Number:

• Home: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Employer Information

- Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- Phone Number: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Type of Business: \_\_\_\_\_

Did you notify your employer of this injury?  Yes  No

Have you retained an attorney?:  Yes  No

If yes, please give name & address: \_\_\_\_\_

Are you currently in litigation for this injury?:  Yes  No  Maybe

Please explain the type of work you were doing at the time you were injured :

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Are you still working?:  Yes  No

Did you miss any work because due to this injury?  Yes  No If yes, how much?: \_\_\_\_\_

Are your work responsibilities restricted as a result of this accident?:  Yes  No

Are you taking any medication for pain caused by this accident?:  Yes  No

Have you been treated by any other doctor for this accident?:  Yes  No

If so, please list doctor's name and address: \_\_\_\_\_

What type of treatment did you receive?: \_\_\_\_\_

How long were you treated by this doctor?: \_\_\_\_\_

Are you feeling:  Better  Same  Worse

Have you ever filed a Workman's Compensation claim before?:  Yes  No

If yes, please describe injury and subsequent treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Worker's Compensation Verification

### Patient Acct#: Section 1 - Patient Data

Injured Worker's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Injury: \_\_\_\_\_

### Section 2 - Employer Information

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is the Company Self-Insured? \_\_\_\_\_

Supervisor: \_\_\_\_\_ Was Injury Reported? Y / N

Reported to Whom? \_\_\_\_\_ Reported on What Date: \_\_\_\_\_

Has Claim been filed with carrier? \_\_\_\_\_ Claim # \_\_\_\_\_

Authorized By: \_\_\_\_\_ Date: \_\_\_\_\_ Denied By: \_\_\_\_\_ Date: \_\_\_\_\_

Person Spoke with: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time \_\_\_\_\_

Verified By: \_\_\_\_\_

### Section 3 -Work Comp Carrier

Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Adjuster: \_\_\_\_\_ Direct Phone # \_\_\_\_\_ ext. \_\_\_\_\_

Adjuster e-mail: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Authorized By: \_\_\_\_\_ Date: \_\_\_\_\_ Denied By: \_\_\_\_\_ Date: \_\_\_\_\_

Denial Reason: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Require Notes Sent With Claim? Y / N

Person Spoke with: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time \_\_\_\_\_

Verified By: \_\_\_\_\_