WORKERS COMPENSATION INSURANCE INFORMATION SHEET

Patient Name: _____

Date of Accident: _____

Place of Accident: _____

Briefly explain how accident occurred:

_____

_____

_____

_____

_____

_____

_____

Employer's Name & Address:

_____

_____

_____

_____

_____

Telephone Number: _____

Supervisor's Name: _____

Worker's Compensation Insurance Company's Name & Address (Include Adjustor Info):

_____

_____

_____

_____

_____

_____

Telephone Number: _____

Case Number: _____

Are you working now? ☐ YES ☐ NO

**** PLEASE NOTIFY THIS OFFICE IF YOU RECEIVE ANY INFORMATON REGARDING YOUR CASE OR MEDICAL COVERAGE ****

**** YOU MUST NOTIFY OFFICE IF YOU ARE GOING TO SEE ANY INSURANCE DOCTORS ****

**** IF YOU HAVE ANY ADDITIONAL TESTING (MRI'S, XRAYS) PLEASE BRING THE RESULTS OF TESTING TO THIS OFFICE ***

I AM AWARE THAT QUEENSBORO OCCUPATIONAL THERAPY, CARLOS MARTINS MUST BE NOTIFIED OF ALL INSURANCE MEDICAL EXAMS (IME). IF I FAIL TO REPORT DENIAL OF TREATMENT I AM RESPONSIBLE FOR ALL FEES FROM THE EXAM DATE.

SIGNATURE: _____

DATE: _____