POMAJZL Chiropractic

R.L. Pomajzl, D.C.

WORKER COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

NAME_____BIRTHDATE_____
ADDRESS_____
CITY_____STATE_____ZIPCODE_____
TELEPHONE_____OCCUPATION_____

EMPLOYER

EMPLOYERS NAME_____
EMPLOYER ADDRESS_____
CITY_____STATE_____ZIPCODE_____
EMPLOYER TELEPHONE_____INJURY VERIFIED BY_____
CONTACT PERSON_____

INJURY INFORMATION

DATE OF INJURY_____APPROX TIME_____AM PM
PLACE OF INJURY_____
ACCIDENT REPORTED TO EMPLOYER?___YES___NO
NAME OF PERSON YOU REPORTED ACCIDENT TO_____
GIVE FULL DESCRIPTION OF HOW ACCIDENT HAPPENED_____

HAVE YOU LOST TIME FROM WORK?__YES___NO HOW MUCH?_____
OTHER DOCTORS SEEN FOR THIS CONDITION:
DOCTOR"S NAME_____DIAGNOSIS_____
WERE XRAYS TAKEN?___YES___NO OTHER TESTS___YES___NO
IF YES, BY WHOM? PLEASE LIST TEST(S) AND RESULT(S)_____

ANY PREVIOUS WORKER COMPENSATION INJURIES____YES___NO
DATE OF PREVIOUS INJURIES_____DESCRIBE PREVIOUS WORKER COMPENSATION INJURIES_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation is denied

Patients Signature_____Date_____