

Name _____ Date _____

HAS THIS VISIT BEEN AUTHORIZED BY YOUR WORKERS COMPENSATION CARRIER? _____

Employer Information

Employer _____ Employer Phone # _____

Employer's Address _____

Person to contact at your employer _____ Phone# _____

Workers Compensation Insurance Carrier

Name of insurer _____ Phone# _____

Address _____

Contact person _____ CLAIM # _____

Date of injury _____ First date of disability _____

How were you injured? _____

Have you had previous treatment for this injury? _____ If yes, when and where? _____

Previous x-rays? _____ CAT scan? _____ MRI scan? _____

Referring physicians name _____

Attorney's name _____ Phone _____

I authorize the release of medical information to my workers compensation insurance carrier. I understand that if my consultation or treatment has not been approved, I will be responsible for the charges.

Signature Date