

**WORK RELATED INJURY
PATIENT INFORMATION**

Today' Date _____

Please Print

Is your visit related to an injury at work? Yes

No, **STOP – THIS IS THE WRONG FORM, RETURN TO THE FRONT DESK**

Name _____ Birthdate _____ Age _____

First Middle Last

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Direct Work #() _____

In case of emergency, name & phone number of nearest relative _____ () _____

If visiting from out of town, local phone number () _____

SS# _____ Drivers License # and State _____

Sex: Male Female Marital Status: S M D W Name of Spouse _____

EMPLOYER INFORMATION:

Did your employer refer you to our office? Yes, name of supervisor who sent you _____

Does your employer have information on file with our office? Yes No, employer contact _____

Employer Name _____

Supervisor Name _____ Supervisor Phone () _____

Employer's Address _____

City & State _____

Occupation _____ Phone () _____

PERSONAL HEALTHCARE INFORMATION:

Insurance Carrier _____ Insurance Group Number _____

Primary Care Physician's Name _____ Phone() _____

AUTHORIZATION:

I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of medical benefits to Memorial Prompt Care Medical Group, Inc. It is understood that I am being treated for a work related injury. If the physician, my employer or claims examiner determine that the injury/illness is not work related, I will be responsible for all charges incurred.

Signature _____ Date _____

If Minor, Responsible Party's Name _____ Relationship to Patient _____

Front office use only:

Entered by:	Account #:	Reviewed by:	Reviewed by:
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Comments:

1s/forms/pt info/WC New Pt Info10/27/04

Original – CHART

Yellow – BILLING (**Attach copy of Ins. card**)