FINN CHIROPRACTIC

Welcome to our office!

WORKMEN'S COMPENSATION

NAME (first, middle, last):_____ DATE:_____

MAILING ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____ SS#_____-_____-_____ DOB:_____

HOME PHONE:_____ CELL PHONE:_____ SEX: M_____ F_____

EMPLOYER: _____ WORK PHONE:_____

WORK COMP CARRIER: _____

ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____

DATE AND TIME OF ACCIDENT; _____ CLAIM # _____

HAVE YOU FILED AN ACCIDENT REPORT WITH YOUR EMPLOYER/SUPERVISOR ? ❑ YES ❑ NO

HAVE YOU RETAINED AN ATTORNEY? ❑ YES ❑ MAYBE ❑ NO

IF SO, NAME AND ADDRESS OF ATTORNEY: _____

I, the undersigned, do specifically direct and authorize any insurance company, adjustor, or attorney to pay direct to Finn Chiropractic the amount of this bill for services in my accidnt case. I also authorize my attending chiropractic physician at Finn Chiropractic to release any information pertinent to my case to any insurance company, adjustor, or attorney involved in the case.

Signature: _____ Date: _____

WORKMEN'S COMPENSATION HISTORY FORM

Patient Name: _____ Today's Date: _____

Date of Accident:_____

Please explain, in detail, how your accident happened:

_____

_____

_____

_____

_____

_____

_____

_____

Where did you feel pain immediately after the accident? _____

Did you return to work? ❑ YES ❑ NO Date returned to work: _____

Did you consult any other doctor? ❑ YES ❑ NO

If yes, give doctor's name: _____

Doctor's diagnosis:_____

What treatments did you receive? _____

Have you ever injured this area before? ❑ YES ❑ NO

If yes, when and how: _____

If you have had a previous on-the-job injury, did you lose time from work? ❑ YES ❑ NO

If you lost time fromwork with inuries prior to this injury, please give the names of doctors consulted:

_____

Do any other diseases or accidents affect your employement? ❑ YES ❑ NO

If yes, please explain: _____

In your work, do you have to favor any part of your body? ❑ YES ❑ NO

If yes, please explain: _____

Do you have a history of absenteeism caused from an accident on the job? ❑ YES ❑ NO

Before this injury, were you capable of working on an equal basis with others your age? ❑ YES ❑ NO

Are your work activities restricted as a result of this accident? ❑ YES ❑ NO

Since this injury, are your symptoms ❑ improving ❑ getting worse ❑ staying the same

Please list any prescriptive mediations you are taking: _____

_____

I guarantee the Workmen's Compensation Form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date:_____