

WORKERS COMPENSATION INFORMATION SHEET

Attorney: \_\_\_\_\_ Date: \_\_\_\_\_

Referral Source: \_\_\_\_\_

PERSONAL INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

SSN: \_\_\_\_\_ D/O/B/: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

FACTS OF INCIDENT

D/O/I/: \_\_\_\_\_ Time: \_\_\_\_\_

Place: \_\_\_\_\_

Admitted Injury: \_\_\_\_\_ Denial Received: \_\_\_\_\_

Description of Incident (What happened?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1) Witnesses (Name, Address, Phone):

\_\_\_\_\_  
\_\_\_\_\_

2) Witnesses (Name, Address, Phone):

\_\_\_\_\_  
\_\_\_\_\_

3) Witnesses (Name, Address, Phone):

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EMPLOYMENT INFORMATION

D/O/I Employer:

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Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Supv. \_\_\_\_\_

Pre- injury Wage Info:

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Current Employment: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Current Wage Info: \_\_\_\_\_

Other Employment: \_\_\_\_\_

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WORK COMP. INSURANCE

Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone N#: \_\_\_\_\_

Carrier 2: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone N#: \_\_\_\_\_

MEDICAL INFO

Injuries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treating Physician: (indicate type - D.C., G.P., Specialist, . .)

1) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Unpaid Bills? \_\_\_\_\_

2) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Unpaid Bills? \_\_\_\_\_

3) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Unpaid Bills? \_\_\_\_\_

Prior Treatment

(Include all prior Dr's seen, including family Dr.)

1) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

2) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

3) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Intervenors (Anyone who paid for med bills, wage loss or other services?)

Type: (Health, GA, Unemployment): \_\_\_\_\_

\_\_\_\_\_  
Policy N#: \_\_\_\_\_ Claim N#: \_\_\_\_\_

2) \_\_\_\_\_

Policy N#: \_\_\_\_\_ Claim N#: \_\_\_\_\_

3) \_\_\_\_\_

Policy N#: \_\_\_\_\_ Claim N#: \_\_\_\_\_