WORK COMP INTAKE FORM

DATE: ______________ MO WC: _____ IL WC: _____

PATIENT'S FULL NAME: ____

PATIENT'S PH: ____________________________ (HOME/CELL) DOB: ______________________

AUTH/REFERRED BY: ____________________________________ PH: ______________________

BODY PART: RIGHT LEFT BL SHOULDER ELBOW KNEE OTHER: ______________________

WHEN DID PROBLEM BEGIN? _______________ HOW LONG HAS IT BOTHEREED YOU? ______________

HOW DID INJURY TAKE PLACE: ____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? YES NO WHOM? ____________________

IMAGING/TESTING: XRAY MRI CT EMG PT INJ OTHER: ____________________________

SPECIFIC DIAGNOSIS GIVEN: ____

SURGERY NEEDED: YES NO IF SO, WHAT: ____________________________________

PRIOR SURGERY FOR THIS PROBLEM: YES NO ____________________________________

EMAIL: ____

ADDRESS: ____

WORK COMP CARRIER: ____________________________________ CLAIM #: ____________________

BILLING ADDRESS: ____

CLAIM ADJUSTOR: ____________________ PHONE #: ____________________ FAX #: ________________

EMAIL: ____

CASE MANAGER: ____________________ PHONE #: ____________________ FAX#: ________________

EMAIL: ____

ATTORNEY: _________________________ PHONE #: ____________________ FAX #: ________________

ATTY ADDRESS: ____

EMPLOYER: ____

APPT DATE / TIME : ________________________________ SCHEDULER'S INITIALS: ________________

For Clinical Staff Only: