PATIENT INTAKE INFORMATION - Worker's Comp

CONFIDENTIAL INFORMATION FOR OUR FILES, UPDATED ANNUALLY

Today's Date _____ **Person Taking Info.** _____ **Number** _____

Last Name _____ **First** _____ **M.I.** _____

Patient Address _____ **Home Phone** _____

City, State, Zip _____ **Work Phone** _____

Phone Other _____

Date of Birth _____ **Gender:** _____ **Patient Fax** _____

Soc. Sec # _____ **Dominant Hand:** _____ **Patient Email** _____

Employer _____ **Drivers License #** _____

Referred By _____ **Family Doctor** _____

Date of Injury _____ **Region injured** _____

Initial Diagnosis _____

In Case of an Emergency Please Contact: _____ **Phone** _____

Relationship: _____ **Address:** _____

RESPONSIBLE PARTY INFORMATION (SELF, SPOUSE, PARENT, LEGAL GUARDIAN):

RESPONSIBLE PARTY _____

ADDRESS _____

HOME PHONE _____ **WORK PHONE** _____

PHONE OTHER _____ **EMPLOYER** _____

INSURANCE INFORMATION:

INSURANCE COVERAGE TYPE ☐ Work Comp ☐ Private ☐ Medicare ☐ Cash ☐ Other

PRIMARY INS CARRIER _____

GROUP/POLICY _____

INSURED _____

ADDRESS _____

DOB _____ **SS#** _____ **PHONE** _____

SECONDARY INSURANCE:

SECONDARY INS CARRIER _____

GROUP/POLICY _____

INSURED _____

ADDRESS _____

DOB _____ **SS#** _____ **PHONE** _____

FINANCIAL AGREEMENT AND INFORMATION RELEASE

Your claim is due to a Worker's Compensation covered injury and to the extent this remains the case your employer and their insurance carrier is responsible for payment for your care. You agree to inform us if there is a change in the coverage of your claim.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. 800-633-2322 www.mbc.ca.gov

Signed:_____ Dated:_____

_____

Parent or Guardian