Worker’s Compensation Intake Form

Patient Name: _____

Date of Accident: _____

Worker’s Compensation Information

Insurance Company: _____

Address: _____

Claim Number:_____

Adjuster: _____

Phone: _____

1. Did you report this accident to your employer? _____
2. Who can we contact at your employer to discuss the accident? _____

   _____
3. Please describe your accident? _____

   _____

   _____

   _____

   _____
4. Did you go to the hospital? _____
5. Which hospital? _____
6. What doctors did you see? _____

   _____

7. What testing did you have done? _____

_____

_____

8. What was your diagnosis? _____

_____

_____

9. Are you seeing any other doctors for this accident? _____

_____

_____

10. What job related activities are you unable to perform because of the injuries you sustained?

_____

_____

_____

11. Date of last day of work? _____

12. Have you returned to work? _____

13. Date you returned to work? _____

14. Do you currently have a lawyer for this accident? _____

15. Lawyers Name: _____

16. Lawyers Address: _____

17. Lawyers Phone: _____

Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such as sums as may be due and owing him for medical service rendered both by reason of this accident and by reason of any other bills that are due his office and to withheld such sums from any settlement, judgment or verdict as may be due necessary to adequately protect said doctor.

I hereby further give a lien on my case to said doctor against and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or me as the result of injuries for which I have been treated in connection there with.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered and that his agreement is made solely further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable on demand.

Date: _____

Patient's Signature: _____

I undersigned being the attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctors named above.

Date: _____

Attorney's Signature: _____

ATTN Attorney: Please sign, date and return one copy to doctor's office at once and keep one of your records.