

NeuroRehabilitation and Neuropsychological Services, PC

Worker's Compensation Information Sheet

Please fill out this form **COMPLETELY**, write N/A where applicable and sign it. Thank you.

Referral Source: _____

Does your Employer have Worker's Comp Insurance? (Please Check) Yes No

Is this your First visit to this Office for this complaint? Yes No

Patient Social Security # _____ -- _____ -- _____

Patient Name: (Last) _____ (First) _____ (MI) _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone () _____

Age: _____ Patient's Date of Birth: _____

Are you Married? (Please Check) Yes No Emergency Phone # _____

Date of Accident: _____ (Required)

Location of Accident: _____

Patient's Employer Information

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Your Employer Phone # () _____ (Required)

Employer's Worker's Comp Insurance Carrier Name _____

Insurance Company Address: _____

Insurance Company Phone # () _____

WC Board Case # _____ Carrier Case # _____

Attorney Name and Address: _____ Tel: () _____

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay NeuroRehabilitation and Neuropsychological Services, PC the usual and customary fees for services rendered me.

Patient's Signature: _____ Today's Date: _____