

Be Truly Well Chiropractic & Day Spa
WORKER COMPENSATION
INFORMATION

Patient's Name _____ Date _____

Employer

Employer Name _____
Employer Address _____
Employer Phone(____) _____ Email _____
Injury verified by (For office use) _____
Contact Person _____

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier _____
Carrier Address _____
Carrier Phone (____) _____ Coverage Verified by _____
Adjuster's Name _____ Claim Number _____
Attorney's Name _____
Attorney's Address _____

Injury Information

Date of injury _____ Time _____ am pm Place of
injury _____ Was the
incident reported to a supervisor? Yes No Name of person you reported
accident to _____ Describe the
incident. _____

Have you lost time from work? Yes • No How much? _____
Were you sent to see a doctor? Yes No Other doctors seen for this condition:
Doctor's name _____ Diagnosis _____
_____ Were X-rays
taken? Yes • No Other Tests? Yes No If Yes, by whom? Please list test(s)
and result(s) _____

Are there problems that effect work? What? _____ Do
you favor 1 side in work? Yes No If so, which
side? _____ Before the
injury did you do work equally to others your age? Yes No Any previous
Worker Compensation injuries? Yes No Date(s) of previous
injuries _____ Describe previous
Worker Compensation injuries _____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility

for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Repres. Relationship to Patient