



WORKER'S COMPENSATION PRE-REGISTRATION/RELEASE FORM

Please be advised that failure to provide this information at the time of your appointment, or within 24 hours, will result in billing you directly. We may be required to contact your employer for additional information regarding your claim, if necessary.

NAME: _____ **SS#** _____

EMPLOYER AT TIME OF INJURY: _____

Address: _____

Phone#: _____ **Contact:** _____

W/C INSURANCE CARRIER: _____

Address: _____

Phone#: _____ **Contact:** _____

DATE OF INJURY: _____ **CLAIM #:** _____

Body Part(s) Injured: _____ **Left/Right**

Brief description how your injury occurred: _____ -

Brief description of job duties: _____

If you return after today, please bring a copy of your job description and inquire with your employer if light work is available. Thank you!

Patient Signature _____ **Date**

Worker's Compensation Patient Information Phone # 315-251-3155