LANCE BERLIN, D.P.M., P.C.
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2330 UNION BOULEVARD
ISLIP, NEW YORK 11751
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WORKMAN'S COMPENSATION INFORMATION SHEET

NAME: ____ DATE OF BIRTH: ____________________

SOCIAL SECURITY NUMBER: ____________________________________ AGE: _________

ADDRESS:

____
STREET CITY STATE ZIP CODE

HOME PHONE: ________________________ CELL: ________________________ WORK: ___________________

DATE OF ACCIDENT/INJURY: _________________________ REFERRED BY: ________________________________

BRIEFLY DESCRIBE THE ACCIDENT AND WHAT PART OF YOUR BODY WAS INJURED: _________________________
____

____

EMPLOYER'S NAME: ________________________________ EMPLOYER'S PHONE NUMBER:___________________

EMPLOYER'S ADDRESS:

____
STREET CITY STATE ZIP CODE

COMPENSATION INSURANCE:____________________________________ PHONE NUMBER:___________________

COMPENSATION ADDRESS:____
STREET CITY STATE ZIP CODE

COMPENSATION POLICY NUMBER:________________________ CASE NUMBER:____________________________

DATE STOPPED WORK: ____________________ DATE RETURNED TO WORK:____________________________

MEDICATIONS:____

____

DRUG ALLERGIES:____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO:____
WITH PROVISIONS OF THE WORKER'S COMPENSATION MEDICAL FEE SCHEDULE FOR SERVICES ATTACHED.

I HEREBY RELEASE ANY MEDICAL INFORMATION TO:____

SIGNATURE: ______________________________________ PRINT: _____________________ DATE: _____________

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WORKMAN'S COMPENSATION INFORMATION SHEET

DATE:______________________________

PATIENTS NAME: ____

DID YOU REPORT THIS TO YOUR EMPLOYER? ______ **DATE OF ACCIDENT:** _____________

WHAT PART OF THE BODY DID YOU INJURE? ____________________________________

HOW DID THIS HAPPEN?
____
____
____

WHERE WERE YOU WHEN THE INJURY OCCOURRED?
____

ARE YOU OUT OF WORK AS A RESULT OF THIS INJURY? ______________

DATE YOU RETURNED TO WORK? _______________

WORKMAN'S COMPENSATION INSURANCE CARRIER:
____

ADDRESS:
____
STREET CITY STATE ZIP CODE

CARRIER CASE NUMBER: ____

WCB NUMBER: ____

CLAIM REPRESENTATIVE: ____

TELEPHONE NUMBER: ________________________ **FAX NUMBER:** ________________________

ATTORNEY: ____

TELEPHONE NUMBER: ________________________ **FAX NUMBER:** ________________________