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WORKMAN'S COMPENSATION FORM

Patient name: _____ Date of Birth_____

Sex M ☐ F ☐ Social Security #_____ Age_____

Home Address: _____

City, State, and Zip: _____-_____-_____

Marital status: Single☐ Married ☐ Divorced ☐ Widowed ☐

Home phone: (_____) _____ Cell phone : _____ Work phone: (_____) _____

Employer: _____Occupation: _____

Employer address:

_____

_____

Spouse or emergency contact: _____

Supervisor: _____

Was this injury reported? No Yes if yes, to whom: _____

What was the date of the above work injury: _____

When was the injury reported to your supervisor or employer: _____

Insurance Company: _____

Address & Phone #: _____

Claim #: _____ Adjuster Name: _____

If you have an attorney, please provide name, address and telephone number:

Please give details of personal health insurance in case this service are not covered by your auto insurance so that we may bill your personal insurance company as a secondary option before billing you directly_____

_____

_____

_____

ASSIGNMENT AND RELEASE

I, The undersigned certify that I (or my Employer) have WORKERS COMPENSATION insurance coverage with_____ **and assign directly to Dr Pecos T. Olurin all insurance benefits, if any, other payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance** submissions.

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT DATE

REVIEWED BY PECOS T