

**WORKER COMPENSATION INFORMATION** Anchored Health Chiropractic PLLC 1060 Curve Crest Blvd #102 Stillwater MN 55082

**Patient Information**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Occupation: \_\_\_\_\_

**Employer**

Employer Name: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Employer Phone: (\_\_\_\_) \_\_\_\_\_ Injury Verified by (For Office Use Only) \_\_\_\_\_  
Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Worker Compensation Carrier (For Office Use)**

Worker Compensation Carrier: \_\_\_\_\_  
Carrier Address: \_\_\_\_\_  
Carrier Phone: (\_\_\_\_) \_\_\_\_\_ Coverage Verified by: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**Injury Information**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Place of Injury: \_\_\_\_\_  
Accident reported to employer?  Yes  No Name of Person you reported accident to: \_\_\_\_\_  
Give full description of how accident happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Have you lost time from work?  Yes  No How much? \_\_\_\_\_  
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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_