NeuroRehabilitation and Neuropsychological Services, PC
Worker's Compensation Information Sheet

Please fill out this form **COMPLETELY,** write N/A where applicable and sign it. Thank you.

Referral Source: ____

Does your Employer have Worker's Comp Insurance? (Please Check) **Yes** ☐ **No** ☐

Is this your First visit to this Office for this complaint? **Yes** ☐ **No** ☐

Patient Social Security # ______________ -- __________ -- ______________________________

Patient Name: (Last) _______________________ (First) _____________________(MI)_______

Street Address: ____

City:_____________________________________ **State:**_________ **Zip:**_______________

Home Telephone ( )____________________

Age: __________ **Patient's Date of Birth:** _________________________

Are you Married? (Please Check) Yes No Emergency Phone # _______________________

Date of Accident: _______________________________ (Required)

Location of Accident: _______________________

Patient's Employer Information

Company Name:____

Address:____

City: ___________________________________ **State:** _____________ **Zip:** _________________

Your Employer Phone # ( )____ (Required)

Employer's Worker's Comp Insurance Carrier Name ________________________________

Insurance Company Address: ____

____

Insurance Company Phone # ( )_____________________________________

WC Board Case # __________________________ **Carrier Case #**_______________________

Attorney Name and Address:__________________________________**Tel:** ( )___________

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay NeuroRehabilitation and Neuropsychological Services, PC the usual and customary fees for services rendered me.

Patient's Signature: _______________________________ **Today's Date:**__________________

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Checked by: ______________________________