

**WORKERS COMPENSATION REGISTRATION FORM**

**Patient Number** \_\_\_\_\_  
Name (Last, First, MI) \_\_\_\_\_  
DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone#: \_\_\_\_\_ Sex: M/F \_\_\_\_\_ Marital Status \_\_\_\_\_ Referring MD: \_\_\_\_\_  
Present Employer: \_\_\_\_\_ Work#: \_\_\_\_\_  
Work Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

**Have you previously been treated by any of these physicians (circle)**

**Dr. Blyznak, Dr. Dubrow, Dr. Schrank, Dr. Hines, Dr. Kurtz,**

**Dr. Petraco, Dr. Levin, Dr. Muhrad, Dr. Oliveto**

**IS THIS A MANAGED CARE WORKERS COMP POLICY!** Yes \_\_\_\_\_ No \_\_\_\_\_

Briefly describe how and where injury occurred \_\_\_\_\_  
\_\_\_\_\_

Was the Accident reported at work? Yes \_\_\_\_\_ No \_\_\_\_\_  
To Whom did you report your accident? (Give name if known) \_\_\_\_\_  
Did they report it to their carrier? Yes \_\_\_\_\_ No \_\_\_\_\_  
Date & Time of Injury \_\_\_\_\_ Injured Body Part \_\_\_\_\_  
Have you ever injured this body part before? \_\_\_\_\_ If Yes Explain: \_\_\_\_\_

**WCB#** \_\_\_\_\_ **Carrier Case#** \_\_\_\_\_

Employer at time of THIS injury \_\_\_\_\_  
Address of Company \_\_\_\_\_  
Employers Phone # \_\_\_\_\_  
Compensation Carriers Name \_\_\_\_\_  
Compensation Carriers Address: \_\_\_\_\_  
Compensation Carriers Phone # \_\_\_\_\_  
Are you presently working? If NO, when did you stop? \_\_\_\_\_  
If YES, (check) \_\_\_\_\_ Regular Duty? \_\_\_\_\_ Light Duty \_\_\_\_\_  
If you stopped, when did you return? \_\_\_\_\_

**Legal**

In the event I fail to

Do you have an Attorney Representing you in this matter? Yes \_\_\_\_\_ No \_\_\_\_\_  
Attorney's Name/Address \_\_\_\_\_  
Attorney Phone # \_\_\_\_\_  
(SHOULD WORKERS COMPENSATION BE DENIED)  
Commerical Insurance Co. Name: \_\_\_\_\_  
Commerical Insurance Co. Address: \_\_\_\_\_  
Subscribers Name: \_\_\_\_\_  
Employers Address: \_\_\_\_\_  
Group # \_\_\_\_\_ ID# \_\_\_\_\_  
**IN CASE OF EMERGENCY CONTACT:** Name: \_\_\_\_\_ Phone# \_\_\_\_\_

prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I hereby agree to pay (MD Name \_\_\_\_\_ his usual and customary fees for services rendered to the above named claimant in the above identified case. I authorize the provider to release any information necessary to substantiate a claim.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

If signed by other than claimant, print below: Name, Address and relationship of signer.

\_\_\_\_\_  
Name & Address Relationship

Checkedby: \_\_\_\_\_ Date: \_\_\_\_\_