# WORKERS' COMPENSATION QUESTIONAIRE

DATE_____

PATIENT'S NAME_____DATE OF BIRTH_____

ADDRESS_____

_____

PHONE #_____ WORK_____CELL_____

SS#_____ EMERGENCY CONTACT_____

**DATE OF ACCIDENT**_____**CLAIM #**_____

TOWN WHERE ACCIDENT HAPPENED_____

DESCRIBE HOW ACCIDENT HAPPENED_____

_____

_____

**EMPLOYER'S NAME**_____

ADDRESS_____

_____

PHONE #_____

**WORKERS' COMP INSURANCE CARRIER**_____

ADDRESS_____

_____

PHONE #_____ADJUSTERS NAME & #_____

HAVE YOU BEEN OUT OF WORK_____ DATE RETURNED_____

DID YOU CONSULT ANY OTHER DOCTOR? YES___NO___

IF SO DOCTORS NAME_____MD.___DO___DDS___

HAVE YOU HAD A WORKMEN'S COMPENSATION CLAIM BEFORE? YES___NO___

DO YOU HAVE AN ATTORNEY_____

NAME OF ATTORNEY_____

ADDRESS_____

_____

PHONE #_____ FAX #_____