

# WORKERS' COMPENSATION REGISTRATION FORM

Referring Physician: \_\_\_\_\_  
Referring MD Phone #: \_\_\_\_\_

PATIENT NUMBER: \_\_\_\_\_

Carrier Case #: \_\_\_\_\_ WCB#: \_\_\_\_\_

1. Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

2. Social Security #: \_\_\_\_\_ 3.. Date of Birth: \_\_\_\_\_ 4. Gender: Male Female

5. Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

6. Home Phone #: \_\_\_\_\_ 7. Cell Phone #: \_\_\_\_\_ 8. E-Mail: \_\_\_\_\_

9. Date of injury/onset of illness: \_\_\_\_\_

10. On the date of injury/illness what was the patient's job title or description: \_\_\_\_\_  
\_\_\_\_\_

11. Briefly describe how and where injury occurred: \_\_\_\_\_  
\_\_\_\_\_

12. Are you presently working? Yes \_\_\_\_\_ No \_\_\_\_\_ If "No" when did you stop? \_\_\_\_\_

If "Yes", (check) Regular Duty? \_\_\_\_\_ Light Duty? \_\_\_\_\_

If you stopped, when did you return? \_\_\_\_\_

13. Employer at time of this injury: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Contact: \_\_\_\_\_

14. Employer's Insurance Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Adjustor Name and Phone #: \_\_\_\_\_

In the event I fail to prosecute the claim for Workers' 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.

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