WORKERS' COMPENSATION QUESTIONNAIRE

DATE ______________________________ PLEASE PRINT

I HAVE NOTIFIED MY EMPLOYER OF THIS WORK RELATED INJURY YES NO

CLAIM NUMBER _______________

PATIENT'S NAME ______________________________

OCCUPATION AT TIME OF INJURY ______________________________

PATIENT'S MAILING ADDRESS ______________________________

SOCIAL SECURITY NUMBER ____________________ PHONE NUMBER __________________

EMPLOYER AT TIME OF INJURY ______________________________

EMPLOYER'S ADDRESS _________________________________ PHONE ________________

DATE OF INJURY ______________________________

HOW INJURY OCCURRED ______________________________

____

____

LOSS OF TIME DUE TO INJURY

LAST WORKING DATE ______________________________

DATE RETURNED TO WORK ______________________________

WORKERS' COMPENSATION INSURANCE CARRIER NAME & ADDRESS (If known) _______

____

____

NAME OF REFERRING PHYSICIAN ______________________________

ADDRESS ______________________________

INSURANCE AUTHORIZATION (Please read & sign)

I hereby authorize Medical Eye Specialists, p.c., to furnish Workers' Compensation insurance carrier any information pertaining to the above injury. I understand that if this claim is denied by Workers' Compensation I am personally responsible for the fee.

DATE ____________________ SIGNATURE ____