

Worker's Compensation Patient History Sheet

Please respond to all questions completely and accurately as this information will assist our office in filing your claim for workers' compensation benefits. Please be advised that if this workers' compensation claim is denied, the bills may be submitted to your private insurance provider of payment, otherwise, the patient will be held responsible for the payment of all bills.

Name _____ Date _____

1. What is your injury date? _____
2. Did your injury occur while you were at work? _____
3. Explain in detail how the injury occurred.

4. What body part(s) did you injure? (Please list all injured areas and indicate left or right where appropriate)

5. What is your occupation? _____
6. Have you seen a physician? _____ If yes, what date? _____
7. What was the physicians' name and address?

8. Have you completed a BWC First Report of Injury for this claim? _____
9. If you have filed a first report of injury, have you received a claim number? _____
If yes, what is the claim number? _____
If no, please complete a first report at this time?
10. Have you been off work due to this injury? _____ If yes, what was your first day off work? _____

11. List any previous surgeries:
Date: ___/___/___ Type: _____ Dr's name: _____
Date: ___/___/___ Type: _____ Dr's name: _____
Date: ___/___/___ Type: _____ Dr's name: _____

12. Are you pregnant? _____
(IF SO MAKE SURE NO XRAYS ARE TAKEN)

13. Do you have any medical problems? If yes, please indicate below:
Heart ___ Lung ___ Nervous System ___ Blood ___ Cancer ___
Other (list) _____

14. Are you allergic to Penicillin? _____
Other drug allergies? _____

15. List any medications you are currently taking for any condition

16. Please give your employers' name: _____

17. Please give your employers' address:

18. Please give your employers' phone: _____

19. Name of Managed Care Organization who handles your employers' workers' compensation program: _____

20. Do you have private insurance coverage? _____ Please provide us with your insurance company and address:

21. Your policy number _____ Group number: _____

22. If you have your insurance card, please provide our office with a copy.

I understand that if this workers' compensation claim is denied, I will be responsible for payment of the bills incurred from treatment of these injuries.

Patient's signature _____ Date _____