

WORKERS COMPENSATION QUESTIONNAIRE

Morgante Family Chiropractic

Today's Date _____

Last Name _____ First Name _____ Initial _____

Street _____ City _____ State _____ Zip _____

Home Phone# _____ Work Phone# _____

SS# _____ Date of Birth _____ Sex _____ Marital Status _____

Email Address _____ Employer _____

Street _____ City _____ State _____ Zip _____

INJURY INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. During the course of your treatment, you may receive important paperwork from other sources regarding your Injury, please bring it into our office so we can make a copy for our records.

Date of Injury _____ Time of Injury _____

Place of Injury (City, Town, or Village) _____

When did your present symptoms appear? _____

Injury was reported to Employer? No Yes To Whom? _____

Please describe how injury occurred, Patient states, "While at work, I _____

Have you seen other doctors for this condition? NO Yes If yes, please provide us with their name(s): _____

Were X-rays taken? NO Yes Other tests? NO Yes If yes, please list test(s) and result(s): _____

Have you lost time from work? No Yes How much? _____

Any previous Worker Compensation injuries? No Yes Please provide us with previous injuries and dates: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature _____ Date _____

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB CASE# (if known)	CARRIER CASE# (if known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOCIAL SECURITY#

CLAIMANT	NAME	ADDRESS
EMPLOYER		
INSURANCE CARRIER		

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 (name of doctor)
 _____ (address of doctor)
 _____ his/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date _____ Signature _____

If signed by other than claimant, print below: name, address, and relationship of signer.

 Name Relationship

 Address