LONG ISLAND MEDICAL CARE SERVICES, P.C.

WORKER'S COMPENSATION PATIENT INFORMATION SHEET

PATIENT INFORMATION

Mr. Mrs. Ms.

Patient Name: ______________________________

Address: ______________________________

City, St. ______________________________

Zip: ____________ Home Phone:( ) ______________

Soc. Security #: ______ - ______ - ______

Sex: **M F** Date Of Birth: ____/____/____

Marital Status: **S M D** Student Status: **PT FT**

Emergency Contact: ______________________

Phone #: ( ) ______________________

EMPLOYER INFORMATION

Company Name: ______________________________ Phone: ( ) ____________

Address: ______________________ City, ST: ______________ Zip: ____________

Employer Contact Person/Title: ______________________________ Phone: ( )____________

Immediate Supervisor: ______________________________ Is he/she aware of injury? Yes No

Your Job Position: ______________________Physical Requirements Of Job: ______________

____

____ Are you currently working? Yes No

Date Of Injury: ______________ Time: ______A.M. ______P.M. City Of Accident: ______________

Explain how injury occurred: ____

____

____

EMPLOYER'S COMPENSATION INSURANCE INFORMATION

check here if you want us to bill your company ☐

Comp. Insurance Carrier: ______________________________ Phone: ( ) ____________

Address: ______________________ City, ST: ______________ Zip: ____________

Policy #: ______________ CC #: ______________ Contact Person: ______________

PLEASE NOTE THAT IN THE EVENT WE ARE UNABLE TO PROCESS YOUR WORKER'S COMP. CLAIM, DUE TO THE VALIDITY OF YOUR WORK RELATED ACCIDENT AND/OR ANY OTHER DISCREPANCIES, YOU WILL BE HELD RESPONSIBLE FOR ALL PAYMENTS RELATING TO YOUR VISITS.

Patient's Signature: ______________________________ **Date**: ______________________

internal use only *(BC ____ WC____ Verified by: __________)*