WORKERS' 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 for 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? ☐ Yes ☐ No
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? ☐ Yes ☐ No If yes, what date? ______________________________
7. What was the physician's name and address?
   ____
   ____
8. Have you completed a BWC First Report of Injury for this claim? ☐ Yes ☐ No
9. If you have filed a first report of injury, have you received a claim number? ☐ Yes ☐ No
   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? ☐ Yes ☐ No If yes, what was your first day off work? ____ /____ /____
11. List any previous surgeries:
    Date: ____ /____ /____ Type: ______________________ Physician Name: ______________________
    Date: ____ /____ /____ Type: ______________________ Physician Name: ______________________
    Date: ____ /____ /____ Type: ______________________ Physician Name: ______________________

WORKERS' COMPENSATION
PATIENT HISTORY SHEET (CONTINUED)

12. Are you pregnant? ☐ Yes ☐ No **(IF YES, MAKE SURE NO X-RAYS ARE TAKEN)**

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

14. Are you allergic to Penicillin? ☐ Yes ☐ No
Other drug allergies? ____________________

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

16. Please give your employer's name: ____________________

17. Please give your employer's address: ____________________

18. Please give your employer's phone: ____________________

19. Name of managed care organization who handles your employer's workers' compensation program:
____

20. Do you have private insurance coverage? ☐ Yes ☐ No
Please provide us with your insurance company name and address:
____
Company Name Street or P.O. Box City State Zip

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 worker's compensation claim is denied, I will be responsible for payment of the bills incurred from treatment of these injuries.

Patient's signature: ____________________ **Date:** ____ /____ /____