## Workers Compensation

**PATIENT NAME**: _____ **Date of Birth** : _____

*For all Workers' Compensation injuries, this form needs to be completed necessary to accurately document your work injury. Please complete this form as accurately as possible.*

*Employeer: _____ Date of Injury: _____*

*Address : _____ State:_____ Zip Code : _____*

*Phone: _____ Fax : _____ Contact : _____*

*Workers' Comp Agency: _____*

*Claim Adjuster: _____ Claim Number: _____*

*Phone: _____ Ext: _____ Fax: _____*

*Address: _____*

*Claim Open Date:_____ Claim Close Date:_____*

*Please explain cause of injury:_____*

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*Did you go to a Hospital or Urgent Care? Yes No*

*If so, where did you go and on what date: _____*

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