WORKER'S COMPENSATION REGISTRATION FORM

Patient Information

Last Name:	First Name:	Middle:	DOB:	Sex: **F / M**
Address:	City:	ST:	ZIP:	SS#:

Primary Language: | **Race:** ☐ ***African American*** ☐ ***Asian*** ☐ ***Hispanic*** ☐ ***White*** ☐ ***Other*** | Marital: S / M / W / D

Please check mark your preferred method of contact.	May we send appointment reminders to your first choice? **YES / NO**

Home ( )	Work ( )	Cell ( )	Email ______

I authorize my physician's office to call and leave a voicemail in regards to appointment reminders and call back request with a family member. **INITIAL** _______

Occupation:	Employer:	Phone: ( )

Employer Address:	City:	ST:	ZIP:

Workers Compensation Information

Work Related Injury? **YES / NO**	**If YES, date of accident?**	**Which EYE is affected?** **RIGHT / LEFT**

Explanation of how injury occurred:

Worker's Compensation Carrier:	Claim Number:		
Address:	City:	ST:	Zip:
Phone ( )	Date Last Worked:		
Adjuster's Full Name:	Phone ( )		

Accident Information

Motor Vehicle / Personal Related Injury? **YES / NO**	**If YES, date of accident?**	**Which EYE is affected?** **RIGHT / LEFT**

Explanation of how injury occurred:

Motor Vehicle Compensation Carrier:	Claim Number:		
Address:	City:	ST:	Zip:

Phone ( )	Date Last Worked:	State Where Accident Occured:

Primary Medical Health Insurance

(*Please provide your insurance card to front desk at the time of check in.*)

Insurance Name:	Policy / Group ID:	**Is Patient the Subscriber?** **YES / NO**

Subscriber Name:	DOB:	SS#:	Phone ( )

Employer Name:	Phone ( )

Address:	City:	ST:	Zip:

All the information provided above is complete and accurate to the best of my knowledge.

Patient Signature:	Date:

If for any reason, the services provided, are denied by your Workman's Comp / Motor Vehicle Carrier, it is the policy of our practice to bill your primary medical carrier. All unpaid balances and or denied claims are the responsibility of the Patient / Guarantor / Legal Guardian.

Patient Signature:________________________________ **Date:**______________