Adventist Health Castle

WORKERS COMPENSATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that the information on this form has been uploaded into the EMR.*

PATIENT INFORMATION

SSN:_____-_____-_____ Home Phone:_____ Cell Phone:_____

First Name:_____ Last Name:_____

Middle Name:_____ Email Address:_____

Provide your email and receive specials, health topics, & more!

Date of Birth_____/_____/_____ Sex at Birth: ❑ M ❑ F ❑Other Marital Status: ❑Married ❑Single

What is your preferred method of communication? ❑ Cell Phone ❑ Home Phone ❑ Email ❑ Mail

Mailing Address:_____ City/State/Zip Code_____

Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ YES ❑ NO

How did you hear hear about us? ❑ Drive By ❑ Insurance ❑ Doctor ❑ Employer ❑ Friend/Family ❑ Hotel ❑ Facebook ❑ Instagram ❑ First Aid Station/Event (Please specify):_____

Preferred Pharmacy Location:_____ **Please indicate specific location and city of preferred pharmacy.*

Primary Care Physician:_____ **Phone Number:**_____

EMERGENCY CONTACT/NEXT OF KIN **Please provide the BEST contact numbers for each contact*

1. Name:_____ Relationship:_____ Phone Number:_____
2. Name:_____ Relationship:_____ Phone Number:_____

EMPLOYERS INFORMATION

Company Name:_____ Supervisor Name:_____

Company Address:_____

Phone Number:_____ Ext._____ Fax Number:_____

DESCRIPTION OF YOUR INJURY

Were you injured at work? __ Yes ___ No **Date of Injury:**_____ **Injured Body Part:**_____

Does your company require a drug screening? ____Yes ____No **If you are unsure, please contact your employer to confirm*

In a short summary, please describe what happened:

_____

_____

WORKERS COMPENSATION INSURANCE CARRIER

Are you a Federal Employee? ____Yes _____No **If yes, please provide any additional document (i.e. CA-16 from your employer) to complete*

Company's Insurance Carrier ****REQUIRED***_____

Adjuster's Name (If applicable):_____ Adjuster's Phone Number:_____

Claim Number (If applicable):_____

PERSONAL INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Member ID Number:_____ Member ID Number:_____

Group Number:_____ Group Number:_____

Policy Holders SSN:_____ DOB:____/____/____ Policy Holders SSN:_____ DOB:____/____/____

Relationship to Patient:_____ Relationship to Patient:_____

Print Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ **Date:**_____