WORK COMP. ACCIDENT HISTORY

NAME: ___________________________ ADDRESS: ____

CITY: __________________________ STATE: _____________ ZIP: _________________

AGE: ____________ Date Of Birth: _________________ Sex: F ( ) M ( )

Date & time of accident: ____

State how the accident happened: ____

____

____

Did you report the accident to your employer? _______

If yes, did you fill out an initial accident form with your employer? ____________

Where were you taken after the accident? ____

Were you hospitalized? ______ If yes, where and for how long? _________________________________

Did you receive care from any other health care specialist? _____________________________________

If yes, who and how long? ____

At the time of the accident where did you feel pain? ____

____

What are your current symptoms? ____

____

Have you ever been injured in a similar manner? _________

If yes, how and when?____

Did you miss any work? ______________ Date returned to work. _________________

Are your work activities restricted in any way due to the accident? ________________

If yes, describe: ____

EMPLOYER INFORMATION

EMPLOYER NAME: _____________________ ADDRESS: ____

CONTACT PERSON: ________________ PHONE#: __________________________________

DATE OF INJURY: _________________ TIME OF INJURY: ____________________________

DATE INJURY WAS REPORTED: _________________ TO WHOM: ____________________________

INSURANCE CO: _____________________ ADDRESS: ___________________________________

PHONE #: _____________________ ADJUSTER: ________________________________

CLAIM#: _________________ POLICY#: __________________________________

Financial Responsibility for Worker's Compensation Injuries

- By law this office has seven days to report a worker's compensation claim to the Industrial Accident Board of Massachusetts. It is YOUR responsibility to provide accurate information concerning your injury within 3 days of starting care at this office. If this information is not provided, you will be presented with a bill, which must be paid in full at that time.

- We will file all the necessary paperwork to process this claim. Although, it is your responsibility to know where you stand at all times concerning this bill at Billerica Chiropractic.

- On a monthly basis you will receive a current statement to keep you informed of the services rendered at this office.

- Any payment for services that the company denies or refuses to cover will become your responsibility.

- It is very important that you follow your plan of care so that you do not jeopardize the validity of your injuries.

I have read and understand this policy.

Patient signature: ________________________________ Date: ________________

Guardian signature: ______________________________ Date: ________________