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WORKMAN'S COMPENSATION INFORMATION

We **must** have the following information filled out for your insurance claim to be processed. If the information is not filled out completely, you will be asked to pay your bill in full each visit. Insurance companies now require this information.

1. Patient's Name _____

2. Date of Birth _____ SS# _____

3. Date of injury _____

4. How and where did the injury occur? _____

5. Name of Employer _____

6. Address of Employer _____

7. Phone Number of Employer _____

8. Workman's Comp Insurance Carrier _____

9. Workman's Comp Address _____

10. Workman's Comp Phone number _____

11. Claim # _____

*The information provided on this Statement of Workman's Compensation
is complete and true to the best of my knowledge.*

Signature _____ Date _____