



## WORKERS' COMPENSATION/NO-FAULT REGISTRATION FORM

### PATIENT INFORMATION

DATE	APPOINTMENT WITH	MR #
PATIENT'S LAST NAME		FIRST NAME
STREET ADDRESS		APT. #
CITY	STATE	ZIP CODE
PATIENT EMPLOYER		PATIENT'S WORK NO. ( )
EMPLOYER'S ADDRESS		CITY STATE COUNTRY
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO.
		CONTACT'S WORK PHONE NO.

### WORKERS COMPENSATION INFORMATION

INSURANCE CARRIER		CONTACT PERSON	
CARRIER ADDRESS		CITY	STATE
		ZIP CODE	PHONE NO. ( )
CARRIER CASE #	COMPBOARD #	DATE LAST WORKED	DATE ABLE TO RETURN TO WORK
			FAX NO. ( )

### NO FAULT INFORMATION

INSURANCE CARRIER		CONTACT PERSON	
CARRIER ADDRESS		CITY	STATE
		ZIP CODE	PHONE NO. ( )
CASE/FILE #	GROUP #	POLICY #	FAX NO. ( )

### INJURY INFORMATION

INJURY DATE	ACCIDENT STATE	ACCIDENT COUNTRY	DISABILITY (NO/PARTIAL/TOTAL)
INJURY TYPE			
<input type="checkbox"/> AUTO <input type="checkbox"/> WORK COMP <input type="checkbox"/> POST-OP <input type="checkbox"/> OTHER <input type="checkbox"/> NONE			
INJURY CAUSE			
<input type="checkbox"/> AUTO <input type="checkbox"/> ANOTHER PART RESP <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> OTHER			
DATE ONSET OF ILLNESS	DATE ONSET OF SIMILAR ILLNESS	DISABILITY FROM	DISABILITY THROUGH

### LAWYER INFORMATION

LAW OFFICE NAME	PERSON HANDLING CASE
LAW OFFICE ADDRESS	PHONE NO. ( )
CITY	STATE
	ZIP CODE
FAX NO. ( )	

### ADDITIONAL INFORMATION

In addition to the assignment of benefits and release of information clauses that I accepted on the main registration form, I also understand that in the event that services rendered are not covered by this WC/NF carrier, a bill for services rendered will be sent to my insurance carrier for payment. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_