Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

Worker Compensation Information

Please complete entire form

Date of Workers Comp Report: _____/_____/_____

_____

Employer name | Employer Address | City/State/Zip code

_____

Employer Phone # | Injury Verified By | Contact Info

_____

Name of Worker Compensation Carrier | Address | City/State/Zip code

_____

Adjuster Name | Phone #

Injury Information

_____AM/PM_____

Date of Injury | Time: | Place of Injury

_____

Accident reported: employer name | Name of person reported to

Please give a full description of how the accident happened:

_____

_____

_____

Have you lost time from work: Yes / No How Much time? _____

Are you seeing other doctors for this injury? Yes / No Doctor(s) Name: _____

Diagnosis:

_____

X-Rays? Yes / No If Yes, Where: _____

Other Tests? Yes / No If Yes, Please tell us where, by whom and the results

_____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that the claims for Worker Compensation benefits are denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges

_____ _____ _____

Printed Name | Signature | Date