WORKER'S COMPENSATION **PLEASE PRINT**

PATIENT: Last Name First M.I.

Address

City State Zip

Home Phone Number ( )

Marital Status: ☐ Single (1) ☐ Married (2) ☐ Divorced (3) ☐ Widowed (4)

Sex: ☐ Male (1) ☐ Female (2)

Date of birth / / Age

Social Security Number

Driver's Lic. Number State

Message Phone Number ( )

INJURY NO. 1 Date of Injury / Onset / / Date First Seen / / Condition

PATIENT'S EMPLOYER:

Employer Name

Occupation ( ) Work Phone

Address

City State Zip

INSURANCE:

Worker's Compensation Insurance Carrier

Policy # Claim #

Group # Phone ( )

Address

City State Zip

Treatment Authorized By

REFERRING SOURCE: (Who sent you to our office?) Code

Name

Facility Name or Other

Address

City State Zip Phone

FAMILY PHYSICIAN: (Primary Care Physician) Code

Physician Name

Office Address

City State Zip Phone

INJURY NO. 2 Date of Injury / Onset / / Date First Seen / / Condition

PATIENT'S EMPLOYER:

Employer Name

Occupation ( ) Work Phone

Address

City State Zip

INSURANCE:

Worker's Compensation Insurance Carrier

Policy # Claim #

Group # Phone ( )

Address

City State Zip

Treatment Authorized By

REFERRING SOURCE: (Who sent you to our office?) Code

Name

Facility Name or Other

Address

City State Zip Phone

FAMILY PHYSICIAN: (Primary Care Physician) Code

Physician Name

Office Address

City State Zip Phone

PHCWCRF

INJURY NO. 3 Date of Injury / Onset / / Date First Seen / / Condition _____

PATIENT'S EMPLOYER:

Employer Name _____ Address _____

Occupation _____ ( ) Work Phone _____ City _____ State _____ Zip _____

INSURANCE:

Worker's Compensation Insurance Carrier _____ Address _____

Policy # _____ Claim # _____ City _____ State _____ Zip _____

Group # _____ Phone ( ) _____ Treatment Authorized By _____

REFERRING SOURCE: (Who sent you to our office?) Code _____

Name _____

Facility Name or Other _____

Address _____

City _____ State _____ Zip _____ Phone _____

FAMILY PHYSICIAN: (Primary Care Physician) Code _____

Physician Name _____

Office Address _____

City _____ State _____ Zip _____ Phone _____

AUTHORIZATION:

I request the payment of any authorized insurance benefits to be made to any physician affiliated with PHC Administration, Inc. for any services provided to me by any physician affiliated with PHC Administration, Inc. I authorize any holder of medical information about me be released to any insurance intermediaries and carriers in compliance with the terms of the confidentiality of Medical Information Act of 1980, Section 50, of the California Civil Code.

I understand that I or my account guarantor is responsible to pay, within 30 days, the amount billed on any service denied as noncovered by my insurance policy. I hereby permit a copy of this authorization to be used in place of the original.

_____ Signature of Patient

_____ Date

_____ Signature of Parent or Guardian

_____ Date

NOTES: _____