St. Elizabeth PHYSICIANS

☐ Workers Compensation Visit ☐ Auto Accident Visit

Patient Name _____ Social Security #_____/_____/_____

Patient Date of Birth _____/_____/_____

Office Location _____

Claim # _____ Date of Injury _____

State in which injury occurred _____

Auto Accident Only – Patient was ☐ Driver or ☐ Passenger

Employer _____

Employer Contact_____ Employer Phone #_____

Employer Address_____

Insurance Carrier_____

Insurance Contact_____ Insurance Phone #_____

Insurance Address_____

Body part affected by injury (please list all involved)

_____

_____

_____

HISTORY OF INJURY (Initial Visit Only)

_____

_____

_____

PHYSICIAN ASSESSMENT

Are findings consistent with reported work injury/auto accident? ☐ YES ☐ NO

Comments_____

_____

DIAGNOSIS

_____

AUTHORIZATION

We are unable to file your claim unless you have provided all of the requested information. If you do not have the information at the time of your visit, contact your employer and request that they provide the requested information to you. Once the information has been provided to our Billing Department, we will file your claim. Please Note: Until the required information has been provided, we will bill the patient directly.

I understand that it is my responsibility to provide St. Elizabeth Physicians/St. Elizabeth Physicians Services with the above requested information in order to file my Workers Compensation and/or Auto claim. If I fail to do so, I understand that I will be responsible for the bill. Furthermore, I hereby authorize any treating physician and/or treatment facility to disclose any information regarding this incident to my employer and worker compensation claims representative, and hereby releases the physicians and treatment facility from any liability arising from such disclosure. I fully understand the instructions above and acknowledge receipt of a copy.

_____	_____	_____	_____
Patient Signature	**Patient Phone #**	**Date**	**Physician Signature & Date**