Auto Insurance/Workers' Compensation Information

Today's Date: _____

Patient Name: _____ Birth date: _____

For Auto Insurance, please complete section 1 only.

For Workers' Compensation, please complete section 1 AND section 2.

SECTION 1

Type of Injury: _____ Date of Injury/Accident: _____

Insurance Carrier Name: _____

Insurance Address: _____

City: _____ State: _____ Zip code: _____

Claim Number: _____ State Where Auto Accident Happened: _____

Contact Person: _____

Phone Number: _____ Extension: _____

SECTION 2

Nurse Case Manager Name: _____ Phone: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip code: _____

Employer Phone Number: _____

Employer Fax Number: _____

Date disability began: _____

Have you missed work due to the injury? ◯ YES ◯ NO

Have you returned to work? ◯ YES ◯ NO If yes, date you returned: _____

Full Duty or Modified/Limited Duty?_____