



# REGISTRATION FORM-Workers' Compensation

(Please Print & Complete All Sections)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PCP \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
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Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former Name)	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )
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Date of onset/problem / /	Occupation	Employer	Employer Phone No. ( )
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Chose Clinic Because/Referred to Clinic By (Please Check one Box)    Dr \_\_\_\_\_    Ins Plan

Hospital    Family    Friend    Close to Home/Work    Yellow Pages    Other \_\_\_\_\_

May we contact you regarding your schedule via email?  Yes    No   *if yes, email address:* \_\_\_\_\_

Other Family Members Seen Here \_\_\_\_\_

## WORKERS' COMPENSATION INSURANCE INFORMATION

Claims Adjuster	Phone No. ( )	Claims Address	Insurance Phone No. ( )
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Nurse Case Manger	Phone No. ( )	Employer Address	Employer Phone No. ( )
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Occupation	Employer	Employer Address	Employer Phone No. ( )
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Date of Injury	Claim Number	Injury Site (i.e. Back, Shoulder, Knee etc)
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## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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Do you have an attorney for this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attorney's Name	Address	Phone No.
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The above information is true to the best of my knowledge. I authorize my Workers' Compensation Insurance benefits be paid directly to *The Jackson Clinics, LLC*. I understand that I am financially responsible for any balance not approved by Workers' Compensation. I also authorize *The Jackson Clinics, LLC* or insurance company to release any information required to process my claims.

x \_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date