the JACKSONCLINICS physical therapy

REGISTRATION FORM–Workers' Compensation
(Please Print & Complete All Sections)

Today's Date ____/____/_____ PCP ____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	▫ Mr. ▫ Miss ▫ Mrs. ▫ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ▫ Yes ▫ No	If not, what is your legal name?	Birth Date / /	Age	Sex ▫ M ▫ F

Street Address	City	State	ZIP Code	Social Security	Preferred Phone No. ( )

Date of onset/problem / /	Occupation	Employer	Employer Phone No. ( )

How did you hear about us? (Please Check one Box) ▫ Dr ____________________ ▫ Ins Plan ▫ Hospital

▫ Family/Friend ▫ Returning Patient ▫ Close to Home/Work ▫ Internet Search ▫ Other____________________

May we contact you via email? ▫ Yes ▫ No *if yes*, email address:____________________

How would you like to receive appointment reminders? ▫ Text cell # (___) ____________ ▫ Email ▫ Call # (___) ____________

WORKERS' COMPENSATION INSURANCE INFORMATION

Claims Adjuster	Phone No. ( )	Claims Address	Insurance Phone No. ( )
Nurse Case Manger	Phone No. ( )		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Date of Injury	Claim Number	Injury Site (i.e. Back, Shoulder, Knee etc)

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

Do you have an attorney for this injury? ▫ Yes ▫ No	Attorney's Name	Address	Phone No.

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, LP*. I understand that I am financially responsible for any balance not approved by Workers' Compensation. I also authorize *The Jackson Clinics, LP* or insurance company to release any information required to process my claims.

× ______________________________ ______________________________
Patient/Guardian Signature Date