WILMINGTON PHYSICAL THERAPY, INC.
WORKERS COMPENSATION PATIENT INFORMATION SHEET

PATIENT:

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE_____

HOME PHONE #:_____WORK PHONE#_____

DATE OF BIRTH:_____ AGE:_____ SEX: M / F

MARITAL STATUS: M – S – D – W RACE:_____

SOCIAL SECURITY #:_____MEDICAL PROBLEM:_____

REFERRING PHYSICIAN:_____

NAME & ADDRESS OF EMPLOYER WHERE INJURY OCCURRED:_____

_____

SUPERVISORS NAME:_____PHONE #:_____

DATE OF INJURY:_____DATE REPORTED:_____

HOW DID THE INJURY OCCUR (PLEASE DESCRIBE):_____

_____

EMPLOYEES HEALTH INSURANCE INFORMATION

THIS INFORATION IS REQUIRED AND WE WILL ONLY BILL YOUR HEALTH INSURANCE COMPANY, IF AND ONLY IF YOUR WORKERS COMPENSATION CLAIM IS DENIED FOR ANY REASON.

NAME OF INSURANCE:_____

POLICY#_____ GROUP#:_____

POLICY HOLDER'S NAME:_____

INSURANCE ADDRESS:_____PHONE#:_____

I AUTHORIZE WILMINGTON PHYSICAL THERAPY, INC. TO RELEASE ALL INFORMATION ACQUIRED IN THE COURSE OF MY TREATEMENT TO THE REFERRING PHYSICIAN AND THE INSURANCE CARRIER AND/OR AGENTS OF MY EMPLOYER. I UNDERSTAND THAT IF MY CLAIM IS DENIED AS A WORKERS COMPENSATION INJURY THAT I AM RESPONSIBLE FOR FULL PAYMENT OF MY BILL. I AGREE TO NOTIFY WILMINGTON PHYSICAL THERAPY, INC. IF I REQUEST A HEARING WITH THE N.C. INDUSTRIAL COMMISSION CONCERNING A DENIAL OF MY CLAIM.

PATIENT'S SIGNATURE:_____DATE:_____

A PHOTOCOPY OF THIS AUTHORIZATION AND ASSIGNMENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.