



WORKERS' COMPENSATION/NO-FAULT REGISTRATION FORM

PATIENT INFORMATION

DATE	APPOINTMENT WITH	MR #
PATIENT'S LAST NAME		FIRST NAME
STREET ADDRESS		APT. #
CITY	STATE	ZIP CODE
PATIENT EMPLOYER		PATIENT'S WORK NO. EXT. ()
EMPLOYER'S ADDRESS		CITY STATE COUNTRY
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO. CONTACT'S WORK PHONE NO.

WORKERS COMPENSATION INFORMATION

INSURANCE CARRIER		CONTACT PERSON	
CARRIER ADDRESS	CITY	STATE	ZIP CODE
CARRIER CASE #	COMPBOARD #	DATE LAST WORKED	DATE ABLE TO RETURN TO WORK
		PHONE NO. ()	
		FAX NO. ()	

NO FAULT INFORMATION

INSURANCE CARRIER		CONTACT PERSON	
CARRIER ADDRESS	CITY	STATE	ZIP CODE
CASE/FILE #	GROUP #	POLICY #	FAX NO.
		PHONE NO. ()	
		FAX NO. ()	

INJURY INFORMATION

INJURY DATE	ACCIDENT STATE	ACCIDENT COUNTRY	DISABILITY (NO/PARTIAL/TOTAL)
INJURY TYPE <input type="checkbox"/> AUTO <input type="checkbox"/> WORK COMP <input type="checkbox"/> POST-OP <input type="checkbox"/> OTHER <input type="checkbox"/> NONE			
INJURY CAUSE <input type="checkbox"/> AUTO <input type="checkbox"/> ANOTHER PART RESP <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> OTHER			
DATE ONSET OF ILLNESS	DATE ONSET OF SIMILAR ILLNESS	DISABILITY FROM	DISABILITY THROUGH

LAWYER INFORMATION

LAW OFFICE NAME	PERSON HANDLING CASE
LAW OFFICE ADDRESS	PHONE NO. ()
CITY	STATE
ZIP CODE	FAX NO. ()

ADDITIONAL INFORMATION

In addition to the assignment of benefits and release of information clauses that I accepted on the main registration form, I also understand that in the event that services rendered are not covered by this WC/NF carrier, a bill for services rendered will be sent to my insurance carrier for payment. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: _____

Date: _____