WORKERS' COMPENSATION INFORMATION FORM

Westfield Family Physicians, P.C.

138 E Main St. PO Box 10, Westfield, NY 14787
115 E Main St. PO Box 570, Sherman, NY 14781

Patient name (claimant) _____ Social Security # _____

Employer / responsible company _____ Date of Birth: ___/___/___

Employer / Company address _____

_____

Employer / Company phone number (___) ___-_____

Workers' Compensation carrier name _____

Workers' Compensation carrier address _____

What Time did the Injury Occur? ___ AM ___ PM

Have you notified your employer of this injury? ◯ YES ◯ NO If not, please do so immediately.

Date of illness or injury ___/___/___ Date of first consultation ___/___/___

Job title on date of injury _____

Is this condition related to employment? ◯ YES ◯ NO

Emergency? ◯ YES ◯ NO If an accident? ◯ Auto ◯ Other

City of occurrence _____

Where did the injury occur? Be specific. _____

How did the injury occur? Be specific. _____

Who at your company can verify this information? _____

Are you continuing to work? ◯ YES ◯ NO

If No, date last worked: ___/___/___

In the event I fail to complete the claim for Workers' Compensation for this illness or condition, or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay the physician's usual and customary fees for services rendered to the above named claimant in the case identified above. I ALSO RELEASE ALL MEDICAL RECORDS REQUESTED BY THE COMPENSATION INSURANCE CARRIER OR EMPLOYER.

Print name _____

Signature _____ Date _____

If signed by an individual other than the claimant, please print your name, address and relationship to claimant.

Print name _____ Relationship _____

Address _____

_____