PRIME MEDICINE, LLC

WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birth date _____ Soc. Sec. # _____
Address _____
_____
Telephone _____ Occupation _____

EMPLOYEE

Employer Name _____
Employer Address _____
Employer Tel. _____ Injury Verified By _____

WORKERS COMPENSATION CARRIER

Workers Compensation Carrier _____
Carrier Address _____
Carrier Tel. _____ Coverage Verified By _____
Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ ☐ AM ☐ PM
Place of Injury _____
Accident Reported to employer? ☐ Yes ☐ No Name of person you reported accident to _____
Give full description of how accident happened _____
_____
_____
_____
_____
Have you lost time from work? ☐ Yes ☐ No How much? _____
Other doctor's seen for this condition:
Doctor's Name _____ Diagnosis _____
Were X- Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No
If yes, by whom? Please list test(s) and result(s) _____
_____
_____
_____
Any previous Workers Compensation Injuries? ☐ Yes ☐ No Dates of previous injuries? _____
Describe previous Workers Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patients Signature _____ Date _____