

WORKER'S COMP PATIENT INFORMATION

Date _____

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____ Sex:

Male Female

Address _____ City: _____

Zip: _____

Social Security #: _____ - _____ - _____ Driver License #: _____

Phone: Home () _____ - _____ Work: () _____ - _____ Cell: () _____ - _____

Marital Status: Single Married Divorce Widowed

Professional Status: Employed Unemployed Retired Student - Part time / Full time

Current Employer: _____ Phone No. () _____ - _____

Address: _____ City: _____ Zip: _____

Name of Person to be contacted in case of emergency: _____ Phone

No: _____

Relationship to patient: _____

WORKERS COMP INSURANCE INFORMATION:

Name of Insurance Company _____ Phone No: _____

Insurance Address: _____ City

_____ Zip: _____

Claim Number: _____ **Adjuster Name:** _____

Date of Injury: _____

Employer at the time of injury: _____ Phone No.: _____

Address: _____ City:

_____ Zip: _____

Lien Case: yes no

ATTORNEY INFORMATION:

Name: _____ Phone No: _____

Address: _____ City: _____

Zip: _____

Contact person: _____

Diagnostic testing Medical Consent: I consent to the administration and performance of all diagnostic procedures which, in the judgment of his/her physician/nurse practitioner that maybe considered necessary or advisable. I also agree that if I decide to leave without receiving treatment and/or without the consent of my physician, then Millennium Imaging will not be liable for any consequences of that decision.

Certification: I certify and understand that I personally completed this form and that all above information is true, correct and complete to the best of my knowledge.

Patient Signature: _____ Date: _____