WORK COMP. ACCIDENT HISTORY

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

AGE: _____ Date Of Birth: _____ Sex: F ( ) M ( )

Date & time of accident: _____

State how the accident happened: _____

_____

_____

Did you report the accident to your employer? _____

If yes, did you fill out an initial accident form with your employer? _____

Where were you taken after the accident? _____

Were you hospitalized? _____ If yes, where and for how long? _____

Did you receive care from any other health care specialist? _____

If yes, who and how long? _____

At the time of the accident where did you feel pain? _____

_____

What are your current symptoms? _____

_____

Have you ever been injured in a similar manner? _____

If yes, how and when?_____

Did you miss any work? _____ Date returned to work. _____

Are your work activities restricted in any way due to the accident? _____

If yes, describe: _____

EMPLOYER INFORMATION

EMPLOYER NAME: _____ ADDRESS: _____

CONTACT PERSON: _____ PHONE#: _____

DATE OF INJURY: _____ TIME OF INJURY: _____

DATE INJURY WAS REPORTED: _____ TO WHOM: _____

WORKER'S COMPENSATION INSURANCE CO: _____

ADDRESS: _____

PHONE #: _____ ADJUSTER: _____

CLAIM#: _____ POLICY#: _____

Financial Responsibility for Worker's Compensation Injuries

- **By law this office has seven days to report a worker's compensation claim to the Industrial Accident Board of Massachusetts. It is YOUR responsibility to provide accurate information concerning your injury within 3 days of starting care at this office. If this information is not provided, you will be presented with a bill, which must be paid in full at that time.**

- **We will file all the necessary paperwork to process this claim. Although, it is your responsibility to know where you stand at all times concerning this bill at Billerica Chiropractic.**

- **On a monthly basis you will receive a current statement to keep you informed of the services rendered at this office.**

- **Any payment for services that the company denies or refuses to cover will become your responsibility.**

- **It is very important that you follow your plan of care so that you do not jeopardize the validity of your injuries.**

I have read and understand this policy.

Patient signature: _____ Date: _____

Guardian signature: _____ Date: _____