Midwest Sports Medicine Institute

Workmans' Compensation Injury Form

Patient's Name _____ **Sex** _____ **Marital Status** _____

Date of Birth _____ **Age** _____ **Social Security Number** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (_____) _____ **Work (_____)** _____ **Cell (_____)** _____

E-Mail Address _____

Emergency Contact _____

Relationship to Patient _____ **Phone (_____)** _____

Local Pharmacy _____ **Phone (_____)** _____

Employer Information

Employer _____ **Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Contact Person _____ **Phone (_____)** _____

Workmans' Compensation Company _____

Address _____ **City** _____ **State** _____ **Zip** _____

Claim Number _____

Contact Person _____ **Date of Injury** _____

Phone (_____) _____ **Ext** _____ **Fax (_____)** _____

Other _____

Injury Information

Have you seen a physician for this injury? _____ **Who?** _____ **When?** _____

I confirm that all statements listed and written are true. I herby authorize mu insurance benefits to be paid to Midwest Sports Medicine Institute. I acknowledge that I am responsible for payment of services should this condition be found not to be work related.

_____ _____

Signature **Date**