WORKERS' COMPENSATION INFORMATION

GULF COAST SPINE CARE LTD., PA

PATIENT NAME:_____

PATIENT PHONE:_____**DATE OF INJURY:**_____

EMPLOYER @ TIME OF INJURY:_____

EMPLOYER'S ADDRESS:_____

_____

SUPERVISOR'S NAME:_____**PHONE #:**_____

IS PATIENT CURRENTLY WORKING? _____YES ____NO

REFERRING PHYSICIAN:_____**PHONE #:**_____

REF. PHYSICIAN ADDRESS:_____

_____

WC CARRIER: _____

CARRIER'S PHONE:_____**FAX #**_____

CARRIER'S ADDRESS:_____

ADJUSTER:_____**CLAIM #**_____

CASE MANAGER:_____**PHONE #:**_____

FAX#:_____

EXAM & TREAT_____ **EXAM & REPORT ONLY**_____

_____

I hereby authorize my medical records to be sent to my employer, agents or representatives of the employer, and to myself, the patient, I am aware the case manager will be in contact with my employer by phone or letter regarding my work situation.

SIGNATURE_____**DATE**_____