New Workers Compensation Client

Full Name:_____ Phone#:_____
Work#:_____
E-mail : _____ Cell#:_____

Mailing Address:_____

_____

Physical Address (If different from above):_____

_____

How did you hear about us?_____

SS#_____DOB:_____

How many years of school completed:_____ Do you have High school Diploma?_____

Employer at Injury_____ Salary at Injury_____

Length of employment prior to injury_____

Current employer if different from employer at time of injury_____

Date of Injury:_____ Adjustor:_____

W/C Insurance Company: _____ Phone#:_____

Fax#_____ Claim# :_____

Insurance Address:_____

_____

How were you injured?_____

_____

What injuries did this accident cause?_____

_____

Doctors/Medical Providers whom have treated you :_____

_____

Prior Injuries- have you injured the same body part?_____

_____

_____

_____

Past Workers Compensation Claims?_____
Dates:_____

Have you filed for Medicare?_____

If yes, when did you file?_____ Medicare Number _____

Do you intend to file for Medicare within the next 3 years?_____

Have you filed for Social Security Disability or Retirement?_____

If yes, when did you file?_____

Do you intend to file for Social Security or Retirement within the next 3 years?_____