Workers Compensation Intake Form

☐ I require translation assistance
☐ J'ai besoin de l'aide de traduction
☐ Я нуждаюсь в помощи переводчика
☐ Requiero ayuda de la traduccion

Translator Information

Date of translation: _____
Print Name: _____
Signature: _____

Did Injury Occur During Your Employment? ☐ **YES** ☐ NO

Date Of Injury:	Time Of Injury:	WCB Case No:	Injury Address:
___/___/___	___:___ AM PM	Carrier Case No:	

Do you have a history of same or similar condition? ☐ YES ☐ NO

If YES , state when and describe:

_____
Patient MUST initial

OCCUPATION:

HOW DID INJURY OCCUR?

PATIENT

LAST NAME	FIRST NAME	MIDDLE NAME	TODAY'S DATE
ADDRESS	SEX	DATE OF BIRTH	SOCIAL SECURITY #
CITY	STATE / ZIP CODE	PHONE NUMBER	ALT.PHONE NUMBER
REFERRING PROVIDER	ADDRESS		PHONE NUMBER

PLEASE ENTER EMPLOYER NAME AT THE TIME OF YOUR INJURY

EMPLOYER

EMPLOYER NAME			
EMPLOYER ADDRESS			
CITY	STATE	ZIP CODE	EMPLOYER PHONE NUMBER
EMPLOYER CONTACT NAME AND PHONE NUMBER			

If treatment was under the VFBL or VAWBL show as “Employer” the liable political subdivision and check one:

☐ YES ☐ NO

PLEASE ENTER <u>WORKERS COMPENSATION</u> INSURANCE INFORMATION

INSURANCE

INSURANCE NAME			
INSURANCE ADDRESS	CITY	STATE	ZIP
POLICY NUMBER	**CLAIM NUMBER**	**POLICY HOLDER**	
CLAIM ADJUSTER NAME	INSURANCE PHONE NUMBER		

_____ _____
Patient Signature Date

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

PATIENT NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

PATIENT ADDRESS:

PROVIDER NAME AND ADDRESS:

I hereby authorize the Healthcare Provider indicated above to furnish copies of all information they have regarding my condition while under their observation or treatment, including the history obtained, diagnostic tests and images such as x-rays and MRIs and physical findings, diagnosis and prognosis. The Healthcare Provider indicated above is authorized to provide this information in accordance with the New York Workers Comprehensive Insurance Reparations Act.

Patient or Guardian Signature: _____

Relationship, if patient is a minor: _____

Date: _____

MEDICAL LIEN

To Attorney: _____
_____
_____

RE: Reports and Lien for: _____
(Patient Name)
Date of Accident: _____

I do hereby authorize the above doctor/medical facility to furnish, you, my attorney, with a full report, diagnosis, treatment plan, prognosis, etc. for myself in regard to the accident in which I was involved.

I hereby authorize and direct, you, my attorney, to pay directly to said doctor/medical facility such sums as may be due and owing said doctor/medical facility for medical services rendered to me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility. I further give a lien on my case to said doctor/medical facility against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or to myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor/medical facility for all medical bills submitted by said doctor/medical facility for services rendered to me and that this agreement is made solely for said doctor/medical facility's additional protection and in consideration of said doctor/medical facility awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover said fee.

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date: _____ Patient's Signature: _____
(Guardian Signature if Patient is a Minor)

The undersigned, being the attorney of record for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility above named.

Date: _____ Attorney's Signature: _____

Authorization for Treatment of a Minor

I, _____, being the parent, legal guardian or adult authorized person persuant to § 2504 of the Public Health Law of New York, of

_____ _____ _____

Name *Relationship* *Birthdate*

give my consent for routine medical and/or diagnostic treatment of this minor at(*Practice Name)* _____. His/her condition requires treatment as per the judgment of his/her healthcare provider. As long as the medical and/or diagnostic treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

If there are medical/physical limitations /prohibitions, specify here:_____
_____
_____
_____
_____

I understand that this authorization is good until the minor mentioned above reaches his/her 18th birthday.

_____ _____

Signature (Parent or Guardian) *Date*

_____

Street Address

_____ _____ _____

City *State* *Zip Code*

_____ _____

Home Telephone *Work Telephone*

Witness:

_____ _____

Signature of staff receiving authorization *Date*