

WORKER COMPENSATION INFORMATION

FULL LEGAL NAME

Last Name _____ First _____ Middle _____

Address _____ City _____
State _____ Zip _____

Home telephone () _____ Date of Birth _____ Sex ____ Age ____

Marital status: ____ single ____ married ____ divorced ____ widow

EMPLOYER INFORMATION AT THE TIME OF YOUR WORK RELATED INJURY:

Company Name _____

Address _____

City _____ State _____ Zip _____

Work telephone () _____ Fax () _____

Human Resources () _____ Fax () _____

Job title: _____

Job duties: _____

WORKER'S COMPENSATION CARRIER INFORMATION –

Date of Injury _____ Body Part injured: _____

Carrier Claim # _____ WCB # _____

Workers Compensation Carrier Name: _____

Adjuster: _____

Telephone () _____ Fax () _____

Date of last Hearing: _____ Date of last IME _____

Attorney Name _____

Telephone () _____ Fax () _____

Injury information Authorization:

I authorize New York Pain Management PLLC to obtain / release all records Pertaining to my work related injury, medical records for treatment rendered. I authorize payment of medical benefits to New York Pain Management PLLC. I promise / understand my responsibility to pay for all medical service disputed or denied by my insurance.

Patient's Signature/ date: _____