

**WORKER COMPENSAZION INFORMATION SHEET  
PATIENT INFORMATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**EMPLOYER INSURANCE INFORMATION**

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Contact: \_\_\_\_\_ Verified (office use): \_\_\_\_\_

Worker Compensation Insurance Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Verified (office use): \_\_\_\_\_ Claim Number: \_\_\_\_\_

**INJURY INFORMATION**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

Brief Description: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Were you seen in a hospital after the accident? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, name of Hospital: \_\_\_\_\_ Location: \_\_\_\_\_

Other Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_

Were x-rays taken? \_\_\_\_\_ Yes \_\_\_\_\_ No Other Tests \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list tests and results: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION**

I hereby authorize Bergen Family Practice of North Jersey to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance. A copy of this authorization may be used in place of the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_