

Campanella Chiropractic
WORKER'S COMPENSATION QUESTIONNAIRE

Today's Date _____

Last Name _____ First Name _____ Initial _____
Street _____ City _____ State _____ Zip _____
Home Phone # () _____ Work Phone # _____ Email _____
Date of Birth _____ Sex _____ SS# _____ - _____ - _____ Marital Status _____
Employer _____ Occupation _____
Street _____ City _____ State _____ Zip _____
How did you hear about our practice? _____

INJURY INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. During the course of your treatment, you may receive paperwork from other sources regarding your injury, please bring it into our office so we can make a copy for our records.

Workers Comp Ins. Co. _____ Phone # _____
Street _____ City _____ State _____ Zip _____
Agent Name _____ Claim # _____
Date of injury _____ Time of injury _____
Place of injury (City, Town, or Village) _____
When did your present symptoms appear? _____
Injury was reported to Employer? ___ No ___ Yes To Whom? _____
Please describe how the injury occurred, patient states, "While at work, I _____

Have you seen other doctors for this condition? ___ No ___ Yes If yes, please provide us with
Their name(s): _____
Where X-Rays taken? ___ No ___ Yes Other tests ___ No ___ Yes If yes, please list test(s)
and results(s): _____
Have you lost time from work? ___ No ___ Yes How much time? _____
Any previous Worker Compensation injuries? ___ No ___ Yes Please provide us with previous
injuries and dates: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature: _____ **Date:** _____