

Atlantis Physical Therapy Group, Inc.

Personalized Fitness Solutions to Enhance People's Lives

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Workers Compensation Intake Form

Intake Date: _____ Interviewer: _____

BASIC PATIENT INFORMATION

Date of Injury: _____ Time of Injury: _____ **AM/PM**

First Name: _____ Last Name: _____ **M / F**

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Date of Birth: _____

Social Security No: _____ License: _____

Marital Status: **Single** **Married** **Divorce**

EMPLOYMENT INFORMATION

Employer Name: _____

Occupation: _____ Tele #: _____

Are you missing time from work? **YES** **NO** (circle one)

How long? _____

WORKERS COMP INFORMATION

Employer's Name: _____

Employer's Phone #: _____ Supervisor's Name: _____

Was injury reported? **YES** **NO** (circle one) to whom: _____

Insurance Company of Employer: _____

Telephone #: _____ Is there a claim set up? **YES** **NO** (circle one)

Claim No: _____ Adjustor: _____

Utilization Company: _____

Contact: _____ Phone No: _____

Visits Approved: _____

INJURY INFORMATION

Was patient removed from the scene by ambulance? **YES NO** (circle one)

Was patient taken to Hospital? **YES NO** (circle one)

Name of Hospital: _____ Date of visit: _____

Were there any X-rays, MRI, etc. performed? _____

What are your major complaints? _____

ATTORNEY INFORMATION

Name: _____

Address: _____

Telephone #: _____ Contact: _____

DESCRIPTION OF ACCIDENT

Brief description of injury, please write below:

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient's Name: _____ Date: _____

Patients Signature: _____