

*Elmwood Orthopedic Rehab Center, Inc.*

*193 Elmwood Avenue*

*Providence, RI 02907*

*Tele: 401.459.4000 Fax: 401.459.4005*

*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: \_\_\_\_\_