

**WORKMANS' COMPENSATION INFORMATION  
PATIENT INFORMATION FORM**

(Please Print)

Have you been a patient at this clinic before? (Circle): Yes No

1. Patient Information

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F  
Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_ Fax:(\_\_\_\_) \_\_\_\_\_  
Best Number: (\_\_\_\_) \_\_\_\_\_ Best time to reach: \_\_\_\_\_  
Employed By: \_\_\_\_\_ Occupation/Dept: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Employment Status: \_\_\_Full-time \_\_\_ Part-time \_\_\_ Retired \_\_\_ Full-time Student \_\_\_Part-time Student

If you advise Burnsville Family Physicians, P.A. that you are covered under your employer's Workmans' Compensation Insurance, we will submit all claims to that company. In order for us to submit your charges to that insurance company:

- 1) A "First Report of Injury" must be completed by your employer
- 2) The form must be forwarded to the insurance in order get your claim processed without a denial. If this report is not filed the insurance company will deny your claim.
- 3) We need the work comp insurance company name, address and contact person.  
In the likelihood that your Workmans' Compensation claim is denied we will file your claim to your health insurance. We ask that you provide us with your health insurance information at the time of your visit for your work related injury.

**If you have any questions concerning benefits or coverage, please contact your Insurance Benefit Department. We do not have access to individual policies and the benefits they cover.**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
Accident/Injury reported to: \_\_\_\_\_ Date of  
Injury: \_\_\_\_\_  
Workmans' Compensation Carrier: \_\_\_\_\_  
Workmans' Compensation Address: \_\_\_\_\_  
Contact Person at Carrier: \_\_\_\_\_  
Phone: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Type of Injury: \_\_\_\_\_

When you date and sign this form you are indicating that you understand and are aware of the release of medical information to the workers' compensation company or your employer.

Please sign and date:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_