NORTHPORT
WELLNESS CENTER
Your Path to Optimal Health

220 Fort Salonga Rd Northport, NY 11768
Phone: 631.262.8505 Fax: 631.754.2909
www.northportwellnesscenter.com

Worker's Compensation Questionnaire

Please print and give complete answers to all questions. Your input will determine if chiropractic can help.

Patient Information

Name: _____ Today's date: _____ Case#: _____ Phone#: _____

Address: _____ City: _____ State: ____ Zip: _____

Social security: _____ Age: _____ D/O/B: _____ Sex: _____ Marital status: ____ #of children: _____

Employer: _____ Address: _____ Phone#: _____

Occupation: _____ Who referred you to us: _____

Accident Information: Dates out of work? From_____to _____

Give all details of how accident occurred:

Worker's compensation insurance company, address & telephone #

_____

Have you retained an attorney?	□ Yes	□ No
Is there litigation?	□ Yes	□ No
After the accident did you return to work?	□ Yes	□ No
Did you consult any other doctor?	□ Yes	□ No
Have you ever injured this same area before?	□ Yes	□ No
If injured before, did you lose work time?	□ Yes	□ No
Do any other diseases or accidents affect your work performance?	□ Yes	□ No
When working, do you have to favor any part of your body?	□ Yes	□ No
Do you have a history of absenteeism because of accidents on the job?	□ Yes	□ No
Have you had a worker's compensation claim before?	□ Yes	□ No
Before the injury, were you capable of working on an equal basis with others your age?	□ Yes	□ No
Are your work activities restricted as a result of this accident?	□ Yes	□ No

Full name & address of attorney (if retained): _____ Phone#: _____

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Worker's Compensation Questionnaire (page 2)

Injury Occurred: Date: _____ Time: _____

In what exact area did you feel pain immediately after the accident?

_____

If you returned to work what was the date?: _____

If you consulted another doctor, give name and degree:

_____

What was the doctor's diagnosis?

_____

What treatments, if any, did you receive?

_____

If you lost time from work with injuries prior to this injury, give the names of the doctor (s) consulted:

_____

_____

If you have other conditions that affect your work performance, explain them:

_____

_____

If you favor any body part while working, explain what is involved:

_____

_____

Since this injury, are your symptoms:

□ The same □ Better □ Worse

Additional Comments:

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Worker's Compensation Authorization

Date: _____

Employer: _____

Address: _____

_____

Employee: _____

Address: _____

_____

Date of Accident: _____

Insurance carrier: _____

Address: _____

_____

By Phone _____ Talked with: _____
(date) (name)

_____ has consulted the _____ clinic for examination and treatment. Please sign and return to the _____ clinic this written authorization for treatment.

_____
Signature, Title

_____
Date

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Worker's Compensation Verification

Patient Name: _____
Address: _____

_____

Social Security No: _____
Telephone No: (_____) _____
Employer Name: _____
Address: _____

_____

Telephone No: (_____) _____
File No: _____
Date of Injury: _____
Reported on: _____
To whom reported it: _____
Dates of Disability: Complete/Partial

_____

_____

Date treatment began:

Insurance Company: _____
Address: _____

_____

Telephone No: (_____) _____
Agent: _____
Address to mail bills: (Lawyer/Insurance/Other

_____

_____

Lawyer's Name _____
Address: _____

_____

Telephone No: (_____) _____
**Problem with receiving payment call Industrial Accident Board.
**Every 30 days: send insurance carrier and employer)if applicable) update.

FOR EMPLOYER:

1. Letter mailed to employer on: _____
2. Letter received from employer on: _____
3. Contract employer - verify date of accident.
4. Did they verify accident and report to insurance company? _____
5. Verify acceptance by insurance company.

FOR LAWYER:

1. Patient signed 3 Liens on: _____
2. 2 Copies of Lien sent to lawyer with cover letter on: _____
3. Should we file bills with Insurance Carrier and/or Attorney? _____
4. Would you like a narrative report on patient? _____
5. How often would like progress report on patient? _____
6. Signed Lien returned from lawyer on: _____

FOR DOCTOR:

1. Will we receive payment as we send in our own bills or do we have to wait for final settlement?

_____

2. Dr. will ask for luncheon date: _____
3. Given Physicians Report on: _____
   (Should be sent out the first billing.)