WORKERS COMPENSATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that this form has been completed and has been uploaded in to the EMR*

PATIENT INFORMATION

SSN:_____ Home Phone:_____

First Name:_____ Cell Phone:_____

Last Name:_____ Email Address:_____
Provide your email and receive specials, health topics, & more!

Middle Name:_____ Date of Birth_____/_____/_____

Mailing Address:_____

Sex: ❑ M OR ❑ F Race:_____ Preferred Language:_____ Hispanic/Latino: ❑ YES ❑ NO

How did you hear hear about us? ❑ Drive By ❑ Insurance ❑ Doctor ❑ Employer ❑ Friend/Family ❑ Hotel ❑ Internet
❑ First Aid Station/Event (Please specify):_____

Preferred Pharmacy Location:_____ ****Please indicate specific location and city of preferred pharmacy.***

EMPLOYERS INFORMATION

Company Name:_____ Supervisor Name:_____

Company Address:_____

Phone Number:_____ Ext._____ Fax Number:_____

DESCRIPTION OF YOUR INJURY

Were you injured at work? ___ Yes ___ No **Date of Injury:**_____ **Injured Body Part:**_____

Does your company require a drug screening? ____Yes ____No **If you are unsure, please contact your employer to confirm*

In a short summary, please describe what happened:

_____

_____

WORKERS COMPENSATION INSURANCE CARRIER

Company's Insurance Carrier **REQUIRED*_____

Adjuster's Name (If applicable):_____ Adjuster's Phone Number:_____

Claim Number (If applicable):_____

PERSONAL INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance:_____

Name of Policy Holder:_____ Name of Policy Holder:_____

Member ID Number:_____ Member ID Number:_____

Group Number:_____ Group Number:_____

Policy Holders SSN:_____ DOB:____/____/____ Policy Holders SSN:_____ DOB:____/____/____

Relationship to Patient:_____ Relationship to Patient:_____

I certify that the information provided is correct to the best of my knowledge. I will not hold Urgent Care Hawaii, LLC, its health providers, or its employees responsible for any errors or omissions that I may have made in completing the information on this form. By signing below, you expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, URGENT CARE HAWAII, LLC, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Print Name of Patient or Guardian:_____

Signature of Patient or Guardian:_____ **Date:**_____