WORKERS COMPENSATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that the information has been reviewed and true*

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.*

Primary Care Physician:_____ **Phone Number:**_____

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. I understand that URGENT CARE HAWAII may contact me with any given contact information provided on this form, this includes my Guarantor's Information and/or Emergency Contact. I understand that I may contacted by WOWZA Management Billing, acting on behalf of Urgent Care Hawaii, LLC regarding any financial responsibilities.

Print Name of Patient or Guardian:_____

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