WORKERS COMPENSATION FORM

Office Use Only:_____ (CSR initial)
**My initial signifies that the information on this form has been uploaded into the EMR.*

PATIENT INFORMATION

SSN:_____-_____-_____Home Phone:_____ Cell Phone:_____

First Name:_____Last Name:_____

Middle Name:_____Email Address:_____

Provide your email and receive specials, health topics, & more!

Date of Birth_____/_____/_____ Sex at Birth: ❑ M ❑ F ❑Other Marital Status: ❑Married ❑Single

What is your preferred method of communication? ❑ Cell Phone ❑ Home Phone ❑ Email ❑ Mail

Mailing Address:_____City/State/Zip Code_____

Race:_____Preferred Language:_____Hispanic/Latino: ❑ YES ❑ NO

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

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

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

EMERGENCY CONTACT/NEXT OF KIN **Please provide the BEST contact numbers for each contact*

1. Name:_____Relationship:_____Phone Number:_____
2. Name:_____Relationship:_____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 URGENT CARE HAWAII'S billing dept., acting on behalf of Urgent Care Hawaii, LLC regarding any financial responsibilities.

Print Name of Patient or Guardian:_____

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