Shepherd Chiropractic

WORKERS COMP CHECK LIST

Date:

First repot filed?	Managed Care Plan?	Referral?	Previous Patient?
◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Last visit: _____

Patient: _____

Date of Injury: _____

Employer: _____

Employer Address: _____

_____ Phone Number: _____

Insurance Company: _____

Insurance Company Address: _____

_____ Phone Number: _____

Claim Rep: _____

Claim #: _____

Attorney Name & Address: _____

_____

_____

_____ Phone number: _____

Health Insurance Name & Address: _____

_____

_____ Phone number: _____

ID#: _____ Group #: _____

Has the patient been treated elsewhere for this injury? ◯ Yes ◯ No

If yes, where? _____

Date last seen? _____

I understand that I am directly and fully responsible for all medical services rendered to me.

Patient Signature: _____ Date: _____

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