Benrus Surgical
at Barnes Jewish St. Peters

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INFORMATION FOR WORKERS COMPENSATION PATIENT

NAME:_____ DATE: _____

ADDRESS:_____ PHONE: _____

_____ CLAIM #: _____

DATE OF BIRTH:_____ AGE: _____

WORK COMP CONTACT NAME:_____ PHONE: _____

EMPLOYER:_____ PHONE: _____

EMPLOYER ADDRESS: _____

DATE OF INJURY:_____ DATE YOU LAST WORKED: _____

PART OF BODY INJURED: _____

X-RAYS TAKEN:_____ WHERE: _____

BRIEF DESCRIPTION OF HOW INJURY OCCURRED: _____

_____

_____

PROBLEMS RESULTING FROM INJURY: _____

_____

MISSED WORK DATES (IF ANY): _____

DATE INJURY REPORTED TO EMPLOYER: _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

NAME OF ATTORNEY:_____ PHONE: _____

I UNDERSTAND IF THIS CLAIM IS DENIED BY WORKERS COMPENSATION INSURANCE, I WILL BE PERSONALLY RESPONSIBLE FOR ANY CHARGES INCURRED IN RELATION TO THE TREATMENT OF THIS INJURY AND AGREE TO PAY ANY SUCH CHARGES.

SIGNATURE:_____ DATE: _____