Benrus Surgical
at Barnes Jewish St. Peters

Kenneth A. Hacker, M.D., F.A.C.S.
Laurel A. Yeager, M.D., F.A.C.S.
Jennifer L. Etling, M.D., F.A.C.S.
Jerad P. Miller, M.D., F.A.C.S
Melissa Franke, F.N.P.-C

70 Jungermann Circle, Suite 405
Saint Peters, MO 63376
636-916-7100
636-916-7110 fax

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: _____