

## WORKERS' COMPENSATION PROPER ADMITTANCE FORM

**NOTICE: If you were injured on the job, you must report the injury to your employer. Failure to do so will result in denial of any payment. In the event that your workers' compensation insurance will not cover, you are responsible for your bill. Thank you.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Name of the person to whom you reported the injury: \_\_\_\_\_

Please explain how the accident happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of present injury: \_\_\_\_\_ Time: \_\_\_\_\_

Did you feel pain immediately at the time of injury? Yes / No

If yes, where? \_\_\_\_\_

If no, please state when you began to have pain and where: \_\_\_\_\_  
\_\_\_\_\_

Did you return to work following the injury? Yes / No

When you reported the injury to your supervisor, were you instructed to see a particular doctor? Yes / No

If yes, whom did you see? \_\_\_\_\_

How much time have you lost from work as a result of this injury? \_\_\_\_\_

Have you ever had a work related injury before? Yes / No

If yes, please indicate when, where and how: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Since this injury, are your symptoms \_\_\_\_\_ improving? \_\_\_\_\_ getting worse? \_\_\_\_\_ the same?

### AGREEMENT TO PAY IN THE EVENT THAT COMPENSATION IS DENIED:

In the event that I fail to prosecute the claim for workers' compensation for this injury or condition, or if it is not a compensable workers' compensation claim, I hereby agree to pay this office usual and customary fee for services rendered to me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**WORKERS' COMPENSATION TREATMENT FORM**

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

\_\_\_\_\_

Physician's Phone # (     ) \_\_\_\_\_

Name of injured employee to receive evaluation/care:

\_\_\_\_\_

Date of Injury: \_\_\_\_\_

Name of Company/Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (     ) \_\_\_\_\_

\_\_\_\_\_ Signature of employer/ manager/  
supervisor (sign in ink)

Date: \_\_\_\_\_

**North Carolina law prohibits an employer from firing, suspending or demoting an employee for filing a Workers' Compensation claim. (NCGS 95-241)**

**Chiropractic IS covered under the Workers' Compensation law and it would be false and misleading for an insurance company or its representatives to state or imply otherwise. (NCGS 97-2(20) & 97-88.2)**

**RETURN THIS FORM TO THE ATTENDING CHIROPRACTIC PHYSICIAN**