Helping Hands Rehab

Worker's Compensation

Patient Information:

First Name:_____ MI: _____ Last Name: _____

Date of Injury: ____/_____/_____ Part of Body injury relates to: _____

Location (City & State) where accident occurred: _____

Complete this section only if the employer <u>at the time of injury</u> is different than your current employer. If you are still employed at the company you were injured at, skip to Worker's Comp Insurance information section below.

Employer Name:_____

Employer Address:_____

City:_____ State: _____ Zip:_____

Work Phone #: (____)_____-_____

Worker's Comp Insurance Information:

Work Comp Carrier Name: _____

Mailing Address:_____

City:_____ State: ____ Zip: _____

Phone: _____ Fax: _____

Claim #:_____

Adjustor's Name:_____

Phone: _____ Fax: _____

Nurse Case Manager:_____

Nurse Case Manager Company: _____

Phone: _____ Fax: _____

10602 Franklin Street–Suite 3, Roscoe, IL 61073 O: 815/623-3700
www.HelpingHandsRehab.com

NOTES/ADDITIONAL INFORMATION:

_____

_____

_____

Patient's Attorney Information: (if applicable)

Attorney Name:_____ Phone #: _____

Firm Name:_____

Address: _____

City:_____ State: _____ Zip: _____