WORKMEN'S COMPENSATION

PATIENT'S INFORMATION

PATIENT'S NAME: _____

ADDRESS: _____

_____

*SOCIAL SECURITY NUMBER*_____

*DATE-OF-BIRTH*_____

*PHONE # : HOME*_____ *WORK* _____

ARE YOU STILL WORKING? YES NO

DATE OF INJURY _____ *BODY PART*_____

*HOW DID INJURY OCCUR ?*_____

_____

EMPLOYER INFORMATION

EMPLOYER _____

ADDRESS _____

_____

*PHONE*_____

WORKMEN'S COMPENSATION INSURANCE

NAME OF INSURANCE CARRIER _____

ADDRESS _____

_____

PHONE _____*CONTACT PERSON*_____

CLAIM # _____ *WCB #* _____

LAYWER'S INFORMATION

NAME OF LAYWER _____

ADDRESS _____

_____

*PHONE NUMBER*_____

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE

TO PROSECUTE OR IF COMPENSTATION CLAIM IS DISALLOWED

WCB CASE NO. (If Known)	*CARRIER CASE NO. (If Known)*	*DATE OF INJURY*	*NATURE OF INJURY OR ILLNESS*	*CLAIMANT'S SOC.SEC.NO.*
CLAIMANT	*NAME*		*ADDRESS*	*APT .*
EMPLOYER				
INSURANCE CARRIER				

In the event I fail to prosecute the claim for worker's compensation for this illness or condition, or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workmen's compensation case, I _____ herby agree to pay Dr. Richard M. Seldes his usual and customary fees for service rendered to the above named claimants in the above identified case.

Date_____ ***Signature_____***

If signed by other than claimant, print below: name, address, and relationship of sign

_____ _____

Name and Address ***Relationship***