

**KIGER STEFFES CHIROPRACTIC SC
WORKER'S COMPENSATION PATIENT INFORMATION**

Name _____ Date _____

Employer _____

Employer Phone _____ Supervisor _____

Have you completed an accident report? YES NO Reported to _____

Have you consulted another health care provider for this injury? YES NO

If yes, please name the doctor and facility _____

Responsible Party / Carrier's Name _____

Address _____

City, State, Zip _____ Phone _____

Claim # _____

Are you represented by an attorney? YES NO

Attorney Name _____ Phone _____

Address _____

City, State, Zip _____

Time and date of injury _____ am / pm _____

Location of Accident _____

Please explain in detail how your accident happened _____

Where did you feel pain *immediately after the accident*? _____

Were you unconscious? YES NO Are your *present* symptoms: Improving? Worse? Same?

Present symptoms _____

Does your condition interfere with your work? YES NO If so, how? _____

I authorize the release of any medical or other information necessary to process this claim. I acknowledge that I am responsible for payment of charges incurred in the event my worker's compensation claim is denied. I authorize the billing of health insurance if benefits are available and assign payment to: Kiger Steffes Chiropractic, S.C.

Signature _____ Date _____