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 / Insurance Carrier's Name____

Address____

City, State, Zip____

Claim #____**FAX# for Claims** ____________________

Adjustor's Name ____________________________________ **Phone**_________________________

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____

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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?___________________________________

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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_________________________