Premier Health Partners, PC
WORKERS COMPENSATION

SUPPLEMENTAL INFORMATION FORM

Please bring all insurance Carrier and Workers Compensation Board Information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

TODAY'S DATE:	**Date of Birth:**
Patient's Name:	**Social Security No:**
Date of Injury:	
Employer Name:	**Employer Address:**
Employer Phone Number: ( )	**Your Job Title:**

Are you out of work due to this injury? □ **Yes** □ **No**

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:	Insurance Carrier Address:
Carrier Claim Number:	WCB Case Number:
Name of Case Manager:	Phone: ( )
	Fax: ( )
Briefly Describe **WHAT** Injury you Sustained:	
Briefly Describe **HOW** Injury Occurred:	

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:
Phone: ( )	Fax: ( )