Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

WORKER'S COMPENSATION REGISTRATION FORM

Patient Information

Last Name:	First Name:	Middle:	DOB:	Sex: **F / M**
Address:	City:	ST:	ZIP:	SS#:
Primary Language:	**Race:** ☐ ***African American*** ☐ ***Asian*** ☐ ***Hispanic*** ☐ ***White*** ☐ ***Other***		Marital: S / M / W / D	
Please check mark your preferred method of contact.		May we send appointment reminders to your first choice? **YES / NO**		
Home ( )	Work ( )	Cell ( )	Email	

I authorize my physician's office to call and leave a voicemail in regards to appointment reminders and call back request with a family member. **INITIAL _____**

Occupation:	Employer:	Phone: ( )
Employer Address:	City:	ST: ZIP:

Workers Compensation Information

Work Related Injury? YES / NO	**If YES, date of accident?**	**Which body part is affected?**
Explanation of how injury occurred:		

Worker's Compensation Carrier:	Claim Number:		
Address:	City:	ST:	Zip:
Phone ( )	Date Last Worked:		
Adjuster's Full Name:	Phone ( )		

Accident Information

Motor Vehicle / Personal Related Injury? YES / NO	**If YES, date of accident?**	**Which body part is affected?**
Explanation of how injury occurred:		

Motor Vehicle Compensation Carrier:	Claim Number:		
Address:	City:	ST:	Zip:
Phone ( )	Date Last Worked:	State Where Accident Occured:	

Primary Medical Health Insurance (*Please provide your insurance card to front desk at the time of check in.)*

Insurance Name:	Policy / Group ID:	**Is Patient the Subscriber? YES / NO**	
Subscriber Name:	DOB:	SS#:	Phone ( )
Employer Name:			Phone ( )
Address:	City:	ST:	Zip:

All the information provided above is complete and accurate to the best of my knowledge.

Patient Signature:	Date:

If for any reason, the services provided, are denied by your Workman's Comp / Motor Vehicle Carrier, it is the policy of our practice to bill your primary medical carrier. All unpaid balances and or denied claims are the responsibility of the Patient / Guarantor / Legal Guardian.

Patient Signature:_____ **Date:**_____