Work Comp Check List

Date: _____

First report of injury filed? Yes No Managed Care Plan? Yes No Previous Patient? Yes No
Referral? Yes No Last Visit _____

Patient: _____

Date of Injury: _____

Employer: _____

Employer'sAddress: _____

_____ Phone: _____

Insurance Company: _____

_____

_____ Phone: _____

Claim Rep: _____

Claim #: _____

Attorney Name & Address: _____

_____

_____

_____ Phone: _____

Health Insurance Name & Address: _____

_____

_____ Phone: _____

ID#: _____ Group #: _____

Has the patient been treated elsewhere for this injury? Yes No
If so, where? _____

Last seen? _____

I understand that I am directly and fully responsible for all medical services rendered to me.

_____

Patient Signature Date

Avenues of Health
2415 Hennepin Avenue South
Minneapolis, MN 55405

Dr. Bob Shepherd
Dr. Paula Allenburg
Dr. Jane Green