Primary Care Clinics of Georgia
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WORKERS COMPENSATION

Name:_____Social Security: _____Date of birth:_____

Address:_____City:_____State:_____Zip:_____

Occupation:_____Phone:_____Sex:____Marital Status:_____

Employer:_____Phone:_____Contact:_____

Employer Address:_____City:_____State:_____Zip:_____

Workers Compensation Insurance: _____Address:_____

Phone:_____Claim #_____Adjuster:_____

Please explain how your injury occurred: _____

_____

Time and Date of Injury: _____Employer reported:_____

Part of Body Injured:_____Employer authorized:_____

Did you return to work? Yes No Date you returned:_____

Did you consult any other doctor? Yes No Doctor's Name:_____

Diagnosis & Treatment:_____

Have you injured this area before: Yes No Date:_____ Treatment:_____

Since this injury are the symptoms: Improving?_____Getting Worse?_____The Same?_____

Are your work activities restricted as a result of this accident? Yes No

When was your last tetanus shot?_____

I understand that I am financially responsible for all charges if this is determined to be not work related. I hereby authorize Primary Care Clinics of Georgia, LLC to release all information necessary to secure payment.

_____ _____ _____ _____
Patient Signature Date Witness Date