DRUG SCREEN? YES/NO
PANEL_____

BREATH ALCOHOL? YES/NO
DOT/NON-DOT

PRIMARY CARE CLINICS OF GEORGIA
DAVID L. HOCKER, MD, MRO
1990 LIMESTONE CIRCLE STE 100
GAINESVILLE GA 30501
P: 770-536-1004 F: 770-536-0905

WORKERS' COMPENSATION

NAME: _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: ___/___/_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____-_____ SEX ASSIGNED AT BIRTH: _____ GENDER IDENTITY: _____

EMPLOYER: _____ CO CONTACT: _____ PHONE: (_____) _____-_____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

WORK COMP INS: _____ ADDRESS: _____

ADJUSTER: _____ PHONE: (_____) ____-_____ CLM#: _____

PLEASE EXPLAIN HOW YOUR INJURY OCCURRED: _____

_____

TIME AND DATE OF INJURY: _____

PART OF BODY INJURED: _____

DID YOU RETURNED TO WORK AFTER INJURY? YES/NO DATE YOU RETURNED: ____/____/_____

DID YOU CONSULT ANY OTHER PHYSICIAN? YES/NO PHYSICIAN'S NAME: _____

DIAGNOSIS: _____

HAVE YOU INJURED THIS ARE BEFORE? YES/NO WHEN? _____ TREATMENT: _____

SINCE THIS INJURY ARE YOUR SYMPTOMS GETTING WORSE/IMPROVING/THE SAME

DO YOU FEEL THAT YOUR WORK ACTIVITIES ARE RESTRICTED AS A RESULT OF YOUR INJURY? YES/NO

WHEN WAS YOUR LAST TETNUS INJECTION? _____/_____/_____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES IF MY INJURY 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: ____/____/_____