WORKER'S COMP PATIENT INFORMATION

Date _____

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____ Sex:

[ ] Male [ ]Female

Address _____ City: _____

Zip: _____

Social Security #: _____-_____-_____ Driver License #:

_____

Phone: Home ( ) _____-_____ Work: ( ) _____-_____ Cell: ( )

_____-_____

Marital Status: [ ] Single [ ] Married [ ] Divorce [ ] Widowed

Professional Status: [ ] Employed [ ] Unemployed [ ] Retired [ ] Student - Part time / Full time

Current Employer: _____ Phone No.( )_____-

_____

Address: _____City: _____ Zip:

_____

Name of Person to be contacted in case of emergency: _____ Phone

No: _____

Relationship to patient: _____

WORKERS COMP INSURANCE INFORMATION:

Name of Insurance Company _____ Phone No:

_____

Insurance Address: _____City

_____Zip:_____

Claim Number: _____ **Adjuster Name:** _____

Date of Injury: _____

Employer at the time of injury: _____Phone No.:

_____

Address: _____ City:

_____ Zip: _____

Lien Case: [ ]yes [ ]no

ATTORNEY INFORMATION:

Name:_____ Phone No:

_____

Address:_____ City:_____

Zip:_____

Contact person:_____

Diagnostic testing Medical Consent: I consent to the administration and performance of all diagnostic procedures which, in the judgment of his/her physician/nurse practitioner that maybe considered necessary or advisable. I also agree that if I decide to leave without receiving treatment and/or without the consent of my physician, then Millennium Imaging will not be liable for any consequences of that decision.

Certification: I certify and understand that I personally completed this form and that all above information is true, correct and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Last updated: 11/7/08