Kiekhoefer Chiropractic
8619 West Point Douglas Rd Suite 110
Cottage Grove, MN 55016

WORKER COMPENSATION INFORMATION

Patient Information

Name:_____ Birthdate:_____ Social Security #_____
Address:_____
Home Phone: (____) _____ E-mail:_____
Cell Phone: (____) _____ Occupation:_____

Employer

Employer Name:_____
Employer Address:_____
Employer Phone: (____) _____ Injury Verified by (For Office Use Only) _____
Contact Person:_____ E-mail:_____

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier:_____
Carrier Address:_____
Carrier Phone: (____) _____ Coverage Verified by:_____
Adjuster's Name:_____ Claim Number:_____

Injury Information

Date of Injury:_____ Time:_____ ❑ AM ❑ PM Place of Injury:_____
Accident reported to employer? ❑ Yes ❑ No Name of Person you reported accident to:_____
Give full description of how accident happened:_____
_____
_____
Have you lost time from work? ❑ Yes ❑ No How much?_____
Other doctors seen for this condition: Doctor's Name_____
Diagnosis:_____ Were X-Rays taken? ❑ Yes ❑ No Other tests? ❑ Yes ❑ No
If yes, by whom? Please list test(s) and result(s) _____
_____
_____
Any previous Worker Compensation injuries? ❑ Yes ❑ No Date(s) of previous injuries:_____
Describe previous Worker Compensation injuries:_____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative:_____ Date:_____

Please Print Name:_____ Relationship to Patient:_____