NYU Langone MEDICAL CENTER

Faculty Group Practice

Workers Compensation / No Fault Insurance Registration Form

DATE: _____ PATIENT NAME: _____ D.O.B: _____

SSN: _____ EMPLOYER _____

OCCUPATION _____ WORK ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____ PHONE # _____

EMERGENCY CONTACT NAME _____ PHONE # _____

ATTORNEY _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PLEASE CIRCLE: NO FAULT or WORKERS COMP (DATE OF ONSET) INJURY OR ACCIDENT _____

INSURANCE COMPANY NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____ POLICY # _____

CLAIM/CARRIER CASE # _____

CLAIM REPRESENTATIVE/ADJUSTOR NAME _____

PHONE # _____ EXT _____ FAX # _____

(OTHER MEDICAL) INSURANCE: _____ ID # _____

PLEASE DESCRIBE THE ACCIDENT _____

_____

WHAT ARE YOUR PRESENT COMPLAINTS AND SYMPTOMS?

_____

_____

_____

DID YOU GO TO THE HOSPITAL? (YES/NO) IF YES, NAME HOSPITAL? _____

WERE X-RAYS, MRI OR CT-SCAN TAKEN? (YES/NO) IF YES, WHAT PROCEDURE? _____ WHAT PART OF THE BODY?

_____ WERE YOU GIVEN ANY MEDICATION? (YES/NO) IF YES, PLEASE LIST

_____

HAVE YOU SEEN ANY DOCTORS SINCE THE ACCIDENT? (YES/NO) _____

IF YES, PLEASE PROVIDE NAME, ADDRESS, AND PHONE #

_____