Labor and Industries Information

Please complete as much information as possible below.

Patient Information

Patient's Name: ____ DOB: ____

Today's Date: ____ Phone: ____

Claim Information

Date of Injury: ____

Claim Number: ____

Body Parts Under This Claim: ____

☐ State Insured or ☐ Self-Insured

If Self-Insured provide the name and mailing address to bill the claim:

Name: ____

Address: ____

City/State/ZIP: ____

Do you have any other open claims for which you are being seen? ☐ Yes ☐ No

If Yes, list the claim number(s) and body part(s):

Claim Number: ____ Body Part(s): ____

Claim Number: ____ Body Part(s): ____

Claim Number: ____ Body Part(s): ____

Claim Manager's Name: ____ Phone: ____

Employer: ____

Attorney Information

Do you have an attorney? ☐ Yes ☐ No

If Yes, Attorney's Name: ____ Phone: ____

Heath Insurance Information

Do you have Regular Health Insurance? ☐ Yes ☐ No

If Yes, Health Insurance Carrier: ____

Insurance ID Number: ____

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