Patient Name:_____ Date of Birth: _____ SS# _____

WORKERS' COMPENSATION
ASSIGNMENT OF BENEFITS

WCB# (If Known): _____ Claim/Case # (If Known): _____

Insurance Carrier: _____ Accident Date: _____

Employer at time of Injury: _____ Employer Phone #: _____

Employer Address: _____

Job Title on date of injury _____

On the date of injury what were your usual work activities? _____

_____

What area(s) were injured: _____

_____

State how injury occurred _____

_____

_____

Did you miss any work: ☐ Yes ☐ No If Yes, date you first missed work _____

Are you working now: ☐ Yes ☐ No

If yes, did you return to : ☐ Usual work duty ☐ Limited work duty

Check all that apply and indicate which body part is affected:

☐ Numbness/Tingling _____ ☐ Swelling _____

☐ Pain _____ ☐ Weakness _____

☐ Stiffness _____ ☐ Other (*specify*) _____

ASSIGNMENT OF BENEFITS (EVERYONE MUST COMPLETE)

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Touch of Life Chiropractic or its Doctors, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance, except in instances were No-Fault or Workers' Compensation fee schedules apply. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

Signature of responsible party: _____ Date: _____