TrustCareHealth™

Workers' Compensation Intake

Name _____ DOB _____/_____/_____

Occupation _____

Is your medical problem the result of an on the job injury? ☐Yes ☐No

Employer _____ Employer Phone _____ Fax _____

Employer Address _____ City _____ State _____ Zip _____

Has your injury been reported? Yes / No If yes, to whom? _____

Date of injury _____ Time of injury _____ Location of accident _____

Have you been seen previously for similar symptoms prior to the accident? ☐Yes ☐No

Have you seen any other doctor(s) since the accident for this injury? ☐Yes ☐No

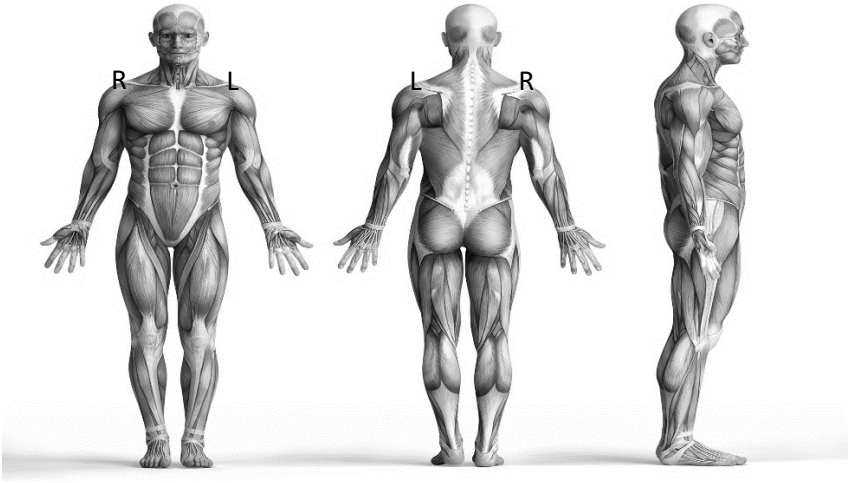
If yes, Facility Name _____ Treating Physician _____

Description of initial injury:

_____

_____

What part/parts of your body were affected? *Circle* all that apply.



Due to various employers' protocols in the state of Mississippi, the patient gives TrustCare Health permission to contact your employer regarding the above claim. Please note that if Workers' Compensation cannot be verified/authorized by employer, payment for services will be expected by patient at the time of service.

Patient Signature X _____ Date _____

Internal Use Only

Employer Contact _____ Title _____ Phone _____

Email _____ Time _____ Date _____

Drug Screen Required? Yes / No If yes, specify type _____

TrustCare Staff Name (print) _____ Date _____