# *Atlantis Physical Therapy Group, Inc.*

*Personalized Fitness Solutions to Enhance People's Lives*
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## *Workers Compensation Intake Form*

Intake Date: ____________________ Interviewer: ________________________

### BASIC PATIENT INFORMATION

Date of Injury: _________________________ Time of Injury: ____________**AM/PM**

First Name: _________________________ Last Name: ______________________________ **M / F**

Address: ___________________________________________________________________

City: ______________________________ State: ______________ Zip: _______________

Home Phone: _______________________ Work Phone: _____________________________

Cell Phone/Pager: ____________________ Date of Birth: ___________________________

Social Security No: _____________________ License: ______________________________

Marital Status: **Single** **Married** **Divorce**

### EMPLOYMENT INFORMATION

Employer Name: ______________________________________________________________

Occupation: ______________________________ Tele #: __________________________

Are you missing time from work? **YES** **NO** (circle one)

How long? ___________________________________________________________________

### WORKERS COMP INFORMATION

Employer's Name: ____________________________________________________________

Employer's Phone #: _____________________ Supervisor's Name: ___________________

Was injury reported? **YES** **NO** (circle one) to whom: _________________________

Insurance Company of Employer: ______________________________________________

Telephone #: ________________________ Is there a claim set up? **YES** **NO** (circle one)

Claim No: _____________________________ Adjustor: ___________________________

Utilization Company: __________________________________________________________

Contact: ________________________________ Phone No: __________________________

Visits Approved: ______________________________________________________________

## INJURY INFORMATION

Was patient removed from the scene by ambulance? **YES** **NO** (circle one)

Was patient taken to Hospital? **YES** **NO** (circle one)

Name of Hospital: ______________________ Date of visit: ____________

Were there any X-rays, MRI, etc. performed? ______________________

What are your major complaints? ______________________

______________________

## ATTORNEY INFORMATION

Name: ______________________

Address: ______________________

Telephone #: ______________________ Contact: ____________

## DESCRIPTION OF ACCIDENT

Brief description of injury, please write below:

______________________

______________________

______________________

______________________

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient's Name: ______________________ Date: ____________

Patients Signature: ______________________