NYU Langone Health

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 #

_____

Revised: 7-27-15