

## Worker Compensation Information

Dr. Cody L. Hoefert, D.C.  
Lyon County Chiropractic  
706 South Ninth Avenue  
Rock Rapids, Iowa 51246  
(712) 472-4732

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation \_\_\_\_\_

### EMPLOYER

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Injury Reported To (FOR OFFICE USE) \_\_\_\_\_

### WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier \_\_\_\_\_

Carrier Address \_\_\_\_\_

Carrier Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Coverage Verified by \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

### INJURY INFORMATION

Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ a.m. / p.m. Place of Injury \_\_\_\_\_

\_\_\_\_\_ Accident Reported to Employer? Yes / No

Name of person you reported accident to \_\_\_\_\_

Give a FULL description of how accident happened \_\_\_\_\_

\_\_\_\_\_

Have you lost time from work? Yes / No How Much? \_\_\_\_\_

Have you seen anyone else for this injury? Yes / No Doctor's Name \_\_\_\_\_ DC / MD / other

Diagnosis \_\_\_\_\_ Were X-rays taken? Yes / No Were other tests performed? Yes / No

Please list those tests and results \_\_\_\_\_

Any other Worker Compensation injuries? Yes / No Dates of previous injuries \_\_\_\_\_

Describe previous Worker Compensation injuries \_\_\_\_\_

### AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_