natural health chiropractic
Dr. Brett Kinsler - Dr. Michalene Elliott

Case # **WORK INJURY REPORT** Page of

PLEASE PRINT

Name _____Date _____

Employer _____ Occupation _____

Employer Phone # _____ Type of Business _____

Worker's Comp Insurance Carrier _____ Phone # _____

Worker's Comp Insurance Carrier Address_____

WCB Case # (if known) _____ Carrier Case # (if known) _____

Private Health Insurance (if Worker's Comp Case is denied)_____

Nature of Injury or Illness

Date of Injury _____ Time of Injury _____ AM PM

Address where you were injured _____

Area of Injury Neck Upper Back Mid Back Lower Back Other_____

Were you previously under care for this injury? No Yes: Doctor's Name _____

Were x-ray's taken for this injury? No Yes: Date and location _____

Please describe how your injury occurred: _____

_____

_____

_____

Have you ever had a similar injury? No Yes: Please describe and give date _____

_____

Are you currently working? Yes No: The last date I worked was: _____

Are you disabled? No Totally Disabled Partially Disabled Temporary Permanent

Agreement to pay medical costs

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay Natural Health Chiropractic, PLLC 2364 Lyell Avenue Rochester, NY 14606, the usual and customary fees for services rendered to me in the above identified case.

_____ _____

SIGNATURE DATE

(If signed by someone other than claimant, print name and address below:)

Name_____

Address _____