AMB Medical Services, P.C.
66 55 Fresh Pond Road
Ridgewood NY 11385

AMB Medical Services, P.C.
68 23 Fresh Pond Road
Ridgewood NY 11385

AMB Medical Services, P.C.
King's Highway
Hauppauge NY 11788

Worker's Compensation Information Form

Demographics:

Patient Name:_____Date ofBirth:_____Sex:_____SS#_____
Address: _____City:_____State:_____Zip Code:_____
Home Phone Number:_____Cell Phone:_____Work Phone:_____

Employer Information:

Employer at the time of injury:_____Phone Number:_____
Company Address:_____City:_____State:_____
Name of the person accident was reported to:_____Contact Number:_____

WC Carrier Information:

Worker's Compensation Insurance Carrier:_____ Phone Number of Carrier:_____
Case Number:_____ Adjuster's Name/Phone No.:_____
Address of Carrier:_____City:_____State:_____Zip Code:_____
Important: ***If you do not have worker's comp CLAIM NUMBER you must provide us with your major medical insurance.***
Case verified by (for front desk use):_____Spoke with (Name/Title):_____

Injury Information:

Date of Injury:_____Time_____AM or PM?_____
Place of Injury:_____Was accident reported to Employer?:_____
Occupation:_____Date last worked?_____
Give Full Description of an accident:_____
_____
_____
Where is your pain located?_____
Do you have any other medical problems at this time?_____
Any previous doctors seen for this condition?_____

I,_____ Hereby agree to pay AMB Medical Services, P.C. in case Workers Comp information is incorrect, denied or inactive, or in the event I fail to prove that the illness or condition is a result of a compensable workers compensation case.
I herby authorize AMB Medical Services, P.C. to release medical information on my injury to the workers compensation carrier.
Date:_____Signed:_____