

Workmans Compensation Information

Patients Name _____ Date of Birth _____

Address _____

Day Time Phone _____ Evening Phone _____

Employer _____ Employer # _____

Social Security # _____ Date of Accident _____

Insurance Company Name _____ Phone # _____

Insurance Company Mailing Address _____

Policy # _____ Claim # _____

Briefly state how the accident occurred.

If the accident involved a motor vehicle please provide no fault information.

What type of radiology examination has been ordered? _____

Who is the referring physician? _____ Physician phone # _____

In the event that I fail to file a no fault claim for this injury or it is determined that the condition is not a result of the above accident, I hereby agree to pay North Fork Radiology, P.C. the usual and customary fees for services rendered. I understand it is my responsibility to obtain the insurance information necessary to process this claim and hereby agree to be responsible for any fees if I fail to obtain said information.

Patient

Signature _____ Date _____