Workers' Compensation/No-Fault
State of New York
Questionnaire

Account#_____

Name_____ Date_____

Address_____

Date of Birth_____ SS #_____

Home Telephone_____ Alternate Telephone_____

Referred by_____ Date of Injury_____

Treating Physician_____ Family Care Practitioner_____

Nature of Injury/Injuries_____

X-rays (Y/N) _____ MRI (Y/N) _____ Other imaging _____

Employer Information:

Name_____

Address_____

Phone_____ Date Reported to Employer_____

Insurance Information:

Carrier_____

Address_____

Phone_____Fax_____Claim Representative_____

WCB Case#_____ Carrier Case #_____

Patient Private Health Insurance: _____Telephone#_____

ID#_____ Group #_____