**Please Print clearly** **ALTMED MEDICAL CENTER**

# Worker's Comp/Auto Accident REGISTRATION FORM

Employer's name: Address: city: state: zip:

| | | | | | | |
|---|---|---|---|---|---|---|
| Contact Person: Phone: | | | | | **Claim no:** | |
| **PATIENT INFORMATION** | | | | | | |
| **Patient's last name :** **First name:** | | | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | **Marital status (circle one)** Single / Mar / Div / Sep / Wid | |
| **Is this your legal name?** ❑ Yes ❑ No | **If not, what is your legal name?** | **(Former name):** | **Birth date:** / / | **Age:** | **Sex:** ❑ M ❑ F | |
| **WC no:** | **Social Security no.:** | | | | **phone no.:** | |
| **Street:** | | **City:** | **State:** | | **ZIP Code:** | |
| **Occupation:** **Supervisor's last name:** | | **Employer:** **First name:** | | | **Employer phone no.:** | |
| **Is this work related injury?** | **yes** **no** | **Date of injury / /** | **Is this a auto related injury** | **Yes** **No** | **Date of injury / /** | |

Please describe how injury occured:

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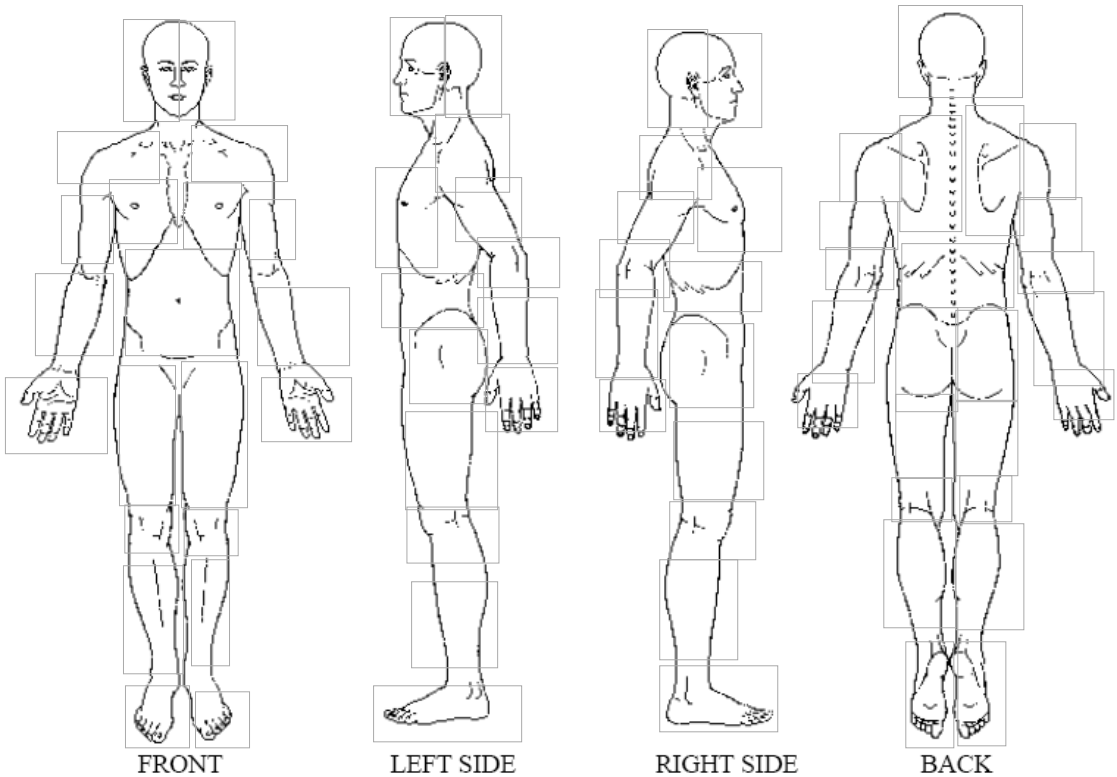



please elaborate : _____

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ALTMED MEDICAL CENTER or worker's comp insurance company and Auto insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*