GLASGOW SPINE & WELLNESS
WILMINGTON SPINE CENTER

WORK COMP CLAIM INFO

PATIENT: _____ DOB:_____

Employer:_____

Employer Phone:_____Employer Fax:_____

Employer Address:_____

Your Occupation:_____

Last Date Worked:_____Are you off work? ____Yes ____No

Claim#:_____ DATE OF ACCIDENT:_____

Injuries reported to Work Comp Insurance:_____

STATE WHERE THE INJURY OCCURRED: _____

Insurance Company:_____

Claim Adjuster:_____Phone:_____

Claim Adjuster's E-mail:_____

Have you contacted an Attorney? ____Yes ____No

Attorney's Name:_____Phone:_____

Address:_____

PATIENT SIGNATURE:_____**DATE:**_____