CENTRE OF PHYSICAL REHABILIATION

2301 COIT RD SUITE B
PLANO, TEXAS 75075
PHONE (972) 599-9191
FAX (972) 599-2323

WORKCOMP PATIENT INFORMATION SHEET

Patient Name: _____

Address: _____City:_____State:_____

DOB: _____Phone:_____Gender:_____Last 4 Digits of SN: _____

Person to Contact in Case of Emergency: _____

Phone: _____ Relationship: _____

WORKCOMP INSURANCE INFORMATION (Required Information)

Employer: _____ Phone: _____

Address: _____City:_____ State:_____

W/C Insurance Company Name: _____Phone:_____

Address: _____City:_____State:_____

Claims Adjustor: _____Phone:_____Claim #:_____

Pre-Authorization Company: _____Phone:_____

Fax Number: _____Billing Company: _____

Address: _____Phone:_____

Physician's Name: _____

Address: _____City:_____ State: _____ Zip Code: _____

I Authorize the provider to provide treatment and authorize that all insurance benefits be paid directly to the provider. I also give the provider authorization to release my personal and medical information to my employer, insurance company, or attorney for the purpose of obtaining payment. I also validate that all the information provided is true, and correct.

Patient Signature: _____Date:_____