Four Pines Physical Therapy

Workers Compensation Information Sheet

Name: _____ Today's Date_____

Did you file an "Employee Report of Injury" with the Wyoming Worker's Safety and Compensation Division? YES / NO

Is this Wyoming Workers Compensation Case? YES NO Case Number: _____

If no, what is the name and state of you Worker's Compensation Case Worker: State:_____

WC Rep Name_____ Phone_____

Employer's Name/Address: _____Phone: _____

_____

Supervisor: _____ Date of Injury (Required): _____

Detailed Description of Injury: _____

_____

Are you currently working: YES / NO If Yes, what is your status: Full-Duty / Light Duty

Have you been seen for a doctor for this problem? YES / NO

If yes, what is your Doctor's Name? _____

Do you have a Doctors Referral for Physical Therapy? YES / NO Is this case in litigation? YES / NO

As a courtesy to our clients, Four Pines PT will bill your personal insurance if Worker's Compensation DOES NOT cover the services provided. To avoid timely filling issues, please provide us with a copy of your primary insurance card/or the following information:

Primary Insurance: _____ Policy: _____

Primary Insured Name: _____ Primary Insured Date of Birth: _____