BENTLEY CHIROPRACTIC, INC.
Michael L. Bentley, DC
Matthew R. Syrek, DC
123 E. William St. Maumee, Ohio 43537
Tel (419) 893-0231
Fax (419) 891-6900

WORKER'S COMPENSATION INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____ Social Security#: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Occupation: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Employer phone #: ( ) _____ Contact Person: _____

INJURY INFORMATION

Date of Injury: _____ Time: _____ ☐ AM ☐ PM

Place of Injury: _____

Injury reported to employer? ☐ Yes ☐ No Person contacted: _____

Description of how accident happened: _____

_____

_____

Description of injuries: _____

_____

ATTORNEY INFORMATION_____

Have you lost time from work? ☐ Yes ☐ No How much? _____

List of Doctor's seen for this condition:

Dr. Name: _____ Diagnosis: _____

Were X-rays taken? ☐ Yes ☐ No

Other tests? ☐ Yes ☐ No If yes, by whom: _____

Previous Worker Compensation injuries? ☐ Yes ☐ No Date(s): _____

Description of previous W/C injuries: _____

I clearly understand and agree that all services rendered to me are billed directly to Worker's Compensation and that I am personally responsible for payment in the event that my claim for Worker's Compensation benefits is denied.

PATIENT SIGNATURE_____DATE_____

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PATIENT PAIN FORM

NAME: _____

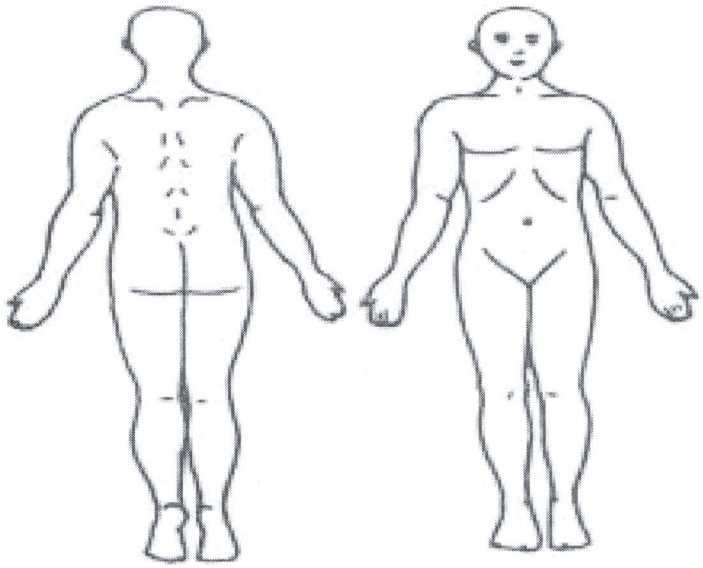
DATE SYMPTOMS OCCURRED: _____

Please circle the level of pain you currently have:

Pain Free 1 2 3 4 5 6 7 8 9 10 **Extreme Pain**

Using the symbols below, mark on the pictures where you feel the described sensations:

Numbness	===
Dull Ache	000
Burning	xxx
Sharp, stabbing	///
Pins, needles	+++
Other	...



_____

PATIENT'S SIGNATURE Date

_____

Physician comments: