Drs. Thomas Politzer & Crystal Kasper

333 South Allison Parkway, Suite 120 Lakewood, CO 80226

Phone: 303-989-2020 Fax: 303-980-5283

WORKER'S COMPENSATION

PATIENT'S DEMOGRAPHICS: **Date:**_____

Last Name: First Name: Middle Initial:

Street Address: City, State, Zip:

Date of Birth: Email:

Cell Phone: Home Phone:

Gender: Male / Female Significant other's name (if applicable):

Employer: Work Phone:

Were you referred to us? Yes / No If yes, by whom?

In case of an emergency, contact person not living with you: Phone:

Date of Accident: Type of Accident:

Adjuster's Name: Adjuster's Phone:

Work Comp Carrier: Claim Number:

Address:

Nurse Case Manager: Phone:

Referring Provider's Name: Authorization Number:

PLEASE PROVIDE YOUR SCRIPT FROM THE REFERRING PHYSICIAN

Medical Records Release:

I authorize the release, or obtaining of information pertaining to examinations in this office, or others, to and from other health care providers, insurance carriers, and/or other professionals as necessary.

Signature (Patient / Parent / Guardian):_____ Date:_____