

WORKER'S COMPENSATION & NO FAULT975 Park Avenue, New York, NY 10028
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Patient's Name: _____ Date: _____

Date of Accident: _____

Describe briefly how your accident occurred: _____

Address of accident: _____

Name and address of Physicians or Hospitals where you were treated:

Body parts injured: _____

Were x-rays taken? Y N When? _____ Where? _____

Types of x-rays taken? _____

Dates you were unable to work? _____

Are you still presently disabled? Y N Why? _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Name of Claims Examiner: _____

Phone Number of Insurance Company: _____

Policy #: _____

Policyholder's Name: _____

Policyholder's address: _____

File or Claim#: _____ Workers' Compensation ID#: _____

Employer's Name: _____

Employer's Address: _____

Lawyer's Name: _____

Lawyer's Address: _____