



Date: \_\_\_\_\_

## WORKERS COMPENSATION REGISTRATION

Name \_\_\_\_\_ Pt. Phone# \_\_\_\_\_

Address \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
\_\_\_\_\_

Employer's Name \_\_\_\_\_ Employer's Phone# \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person at Employer \_\_\_\_\_

Is employer self-insured? (Circle) Yes No I do not know

Date of Injury \_\_\_\_\_ Claim # assigned for injury \_\_\_\_\_

Nature of Injury \_\_\_\_\_

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1. Have you been treated for this injury before? Yes No

If "Yes", full name of physician first treating you for this injury:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

PLEASE COMPLETE "Change of Physician" C-23 FORM.

If "NO", please fill out FROI form.

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2. Have you been treated by this Physician before? Yes No

If "YES", what was the last date seen? \_\_\_\_\_

NOTE: If greater than 1 year ago, PLEASE COMPLETE C-9 FROM

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Do you have commercial insurance that will cover your doctor bills if workers' compensation does not cover them? Yes No

If "YES", Name of Insurance Co. \_\_\_\_\_

Name of Subscriber \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

I understand that I am responsible for my bill for services rendered to me by Dr. \_\_\_\_\_ until the Ohio Bureau of Workers' Compensation or my self-insured employer pays.

Date \_\_\_\_\_ Signature \_\_\_\_\_