

Workers' Comp Registration  
(Please print clearly)

**PATIENT NAME:** \_\_\_\_\_  
Last First Middle

**DATE OF BIRTH:** \_\_\_\_\_ **MARITAL STATUS:** \_\_\_\_\_

**PATIENT ADDRESS:** \_\_\_\_\_  
Street or Route  
\_\_\_\_\_  
City State ZIP

**PATIENT'S SOCIAL SECURITY NR:** \_\_\_\_\_ **SEX:**(circle one) MALE FEMALE

**PATIENT'S HOME PHONE:** \_\_\_\_\_ **WORK PHONE** \_\_\_\_\_

**NAME AND ADDRESS OF EMPLOYER:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When you indicate that payment for services is the responsibility of your employer under workers' compensation, you grant permission to release information about your visit to your employer, your employer's workers' comp insurance company, and the Minnesota Department of Labor and Industry.

The initial claim for payment as well as the copies of your medical records will be sent directly to your employer's workers' comp insurance company. Only if your employer self-insures for workers' comp claims will the initial claim be sent to your employer. Your employer is responsible for informing you of the complete name and address of the insurance company where your claim should be sent. If you know that information, please list it below. If you do not have this information with you, you may list the name of your employer, and we will find out the name and address of your employer's workers' comp insurance company.

NAME AND ADDRESS OF WORKERS' COMP INSURANCE COMPANY \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the event that your employer asks for information regarding your claim, we will send the information to the individual making the request.

I realize that by indicating that this is a workers' compensation claim I am authorizing the Family Medical Center to release any information pertaining to my workers' comp services to my employer, my employer's workers' comp insurance company, and the Minnesota Department of Labor and Industry. I further authorize payment of benefits directly to the Family Medical Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original.

\_\_\_\_\_  
Signature  
900-301 September, 2005

\_\_\_\_\_  
Date