Pain Institute of Long Island

635 Belle Terre Rd - Suite 209
Port Jefferson, NY 11777

300 Old Country Rd - Suite 1
Riverhead, NY 11901

205 Froehlich Farm Blvd
Woodbury, NY 11797

77 N. Centre Ave Suite 202
Rockville Centre, NY 11570

Workers Comp Case

Today's Date: _____

Name:_____ Date of Birth: _____

SSN: _____

Date of Accident: _____ Location of Accident: _____

Do you have more than one WC case? □ Yes, please complete form for each case □ No

Carrier Case #:_____ WC Case #: _____

Body Part Injured: □ Mid and Lower Back □ Neck □ Left Shoulder □ Right Shoulder

□ Left Knee □ Right Knee Other: _____

Employer at time of Accident: _____

Employer Address: _____

Name of Supervisor/Manager: _____

Are you currently working ☐ No

☐Yes When did you return to work?_____

<u>Workers Compensation Insurance Carrier</u>:

_____

Address: _____

Workers Comp Case Manager:_____

Case Manager Telephone Number: _____ Fax :_____

<u>Internal Use:</u>

Date Confirmed: _____

Staff Initials: _____