

Work Injury Visits

Welcome to Fremont Family Practice. We are happy to help provide medical care following your work place injury. In order for us to evaluate you and treat you for your medical needs we ask that you complete and sign this form and bring it to your visit.

Name: _____ Date of Injury: _____

Date of Birth: _____ Age: _____

Please describe your injury: _____

Any history of similar injuries: _____

Date of your first sought medical care for this injury: _____

Have you notified your supervisor: YES/NO

Place of Employment (name and address): _____

Chronic Medical Problems: (if any)

1. _____

2. _____

3. _____

4. _____

Medications: (if any)

1. _____

2. _____

3. _____

4. _____

Payment for services/Consent

Work injuries are not covered by any health insurance plans. Coverage is through Washington State Department of Labor and Industries. This insurance is something your employer carries for all workers. You will be asked to complete an L & I form in our office (we have the forms in our office). While L & I approves most injuries we cannot guarantee this. If your claim is not covered you will be responsible for payment of any medical services provided.

I understand that I will be financially responsible for any medical services not covered by Washington State Department of Labor and Industries.

NAME: _____

DATE: _____

SIGNATURE: _____