Labor and Industries Information

Please complete as much information as possible below.

ORTHOWASHINGTON

Patient Information

Patient's Name: _____ DOB: _____

Today's Date: _____ Phone: _____

Claim Information

Date of Injury: _____

Claim Number: _____

Body Parts Under This Claim: _____

☐ State Insured or ☐ Self-Insured

If Self-Insured provide the name and mailing address to bill the claim:

Name: _____

Address: _____

City/State/ZIP: _____

Do you have any other open claims for which you are being seen? ☐ Yes ☐ No

If Yes, list the claim number(s) and body part(s):

Claim Number: _____ Body Part(s): _____

Claim Number: _____ Body Part(s): _____

Claim Number: _____ Body Part(s): _____

Claim Manager's Name: _____ Phone: _____

Employer: _____

Attorney Information

Do you have an attorney? ☐ Yes ☐ No

If Yes, Attorney's Name: _____ Phone: _____

Heath Insurance Information

Do you have Regular Health Insurance? ☐ Yes ☐ No

If Yes, Health Insurance Carrier: _____

Insurance ID Number: _____

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