

**WORKERS' COMPENSATION**

Hand & Microsurgery Associates

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**EMPLOYEE INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Hm Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

**EMPLOYER INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**WORKERS' COMPENSATION CARRIER INFO.**

Case Number: \_\_\_\_\_

Name: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Adjustor: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**INJURY INFORMATION**

1.) Date of Injury: \_\_\_\_\_

2.) Has employer made a first report of injury to their worker's compensation carrier? Y N

3.) Have you sought other medical treatment for this injury? Y N

4.) Have you had any x-rays, MRIs, or other testing for this injury? Y N

5.) Give a brief description of injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\* PRIOR TO SCHEDULING AN APPOINTMENT YOU MUST HAVE YOUR ADJUSTOR CALL OUR OFFICE. \*\*\***

I understand that if the Workers' Compensation carrier denies my claim I will be responsible for payment of all services associated with this injury. In the event my Workers' Compensation carrier denies my claim, my private health insurance carrier is (name/phone#) \_\_\_\_\_, my member ID# is \_\_\_\_\_, with a group# of \_\_\_\_\_.

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