Michael L. Parks, MD
NF/WC Insurance Form

Patient Name: _____ SSN: _____

Insurance Carrier: _____

Insurance Address: _____

Adjuster's Name: _____

Phone: _____ Fax: _____

Insurance Claim/Policy #: _____

Date of Accident: _____

State of Accident: _____

Attorney Name/Address: _____

_____

Attorney Phone Number: _____

Workers Compensation (complete only if workers compensation)
Employer information on the Date of Injury/Illness

Employer Name: _____ Phone: _____

Employer Address: _____

Job Title/Description: _____

Usual Work Activities: _____

Are you currently working? (please circle) Yes or No