



AcupunctChi Clinic

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WORKERS COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____

Social Security # _____

Address _____

Telephone (home) _____ (work) _____

Occupation _____

EMPLOYER

Employer's Name _____

Employers Address _____

Employers Telephone # _____

Injury verified by _____

Contact Person _____

CARRIER INFORMATION

Workers Compensation Carrier _____

Carrier Address _____

Carrier Phone Number _____

Adjuster _____

Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ AM PM

Place of Injury _____

Was Accident Reported to Employer? yes no

Name of person who took accident report _____

How did accident happen? _____

Have you lost time from work? yes no How much? _____

Have you seen another physician for this condition? yes no

Doctor's Name _____

Were x-rays taken? yes no Other test? yes no

If Yes, please list tests taken and by whom _____

Do you have any previous Workers Compensation Injuries, if yes, please explain _____

AUTHORIZATION

I hereby assign, transfer, and set over to _____ all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's
Signature _____

Date _____