

**ROBBINSDALE MEDICAL CLINIC**

**WORKERS' COMPENSATION REGISTRATION FORM**

Have you been seen at the clinic since March 9, 2009? Yes\_\_\_ No\_\_\_

**PLEASE PRINT CLEARLY**

Social Security # \_\_\_\_\_ Employee ID # \_\_\_\_\_  
(if known)

**NAME:**

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

**ADDRESS:**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

SSN: \_\_\_\_\_ or CLAIM #: \_\_\_\_\_ (You must provide either one)

Describe Injury: \_\_\_\_\_  
\_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Who authorized your visit? \_\_\_\_\_

I have been offered a copy of NorthWorks Privacy Policy

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

\*\*\*\*\*Clinic Use Only Below This Line\*\*\*\*\*

Work Comp Carrier \_\_\_\_\_ Claim # \_\_\_\_\_

Work Comp Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Adjuster \_\_\_\_\_