MED CENTRAL HEALTH RESOURCES, INC.
3424 Clemson Blvd Anderson, SC 29621
Ph: 864-261-3022 Fax: 864-224-5990

Social Security Number: _____

Name: _____

Gender: _____ M _____ F Date of Birth: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Employer (Company that sent you): _____

Employer Contact: _____ Phone No.: _____

Emergency Contact Person: _____

Relationship: _____ Phone No.: _____

I have correctly completed this form.

Signed: _____ Date: _____

3424 Clemson Blvd
Anderson, SC 29621

MED CENTRAL HEALTH RESOURCES

Workers' Compensation Form

Ph# 864-261-3022
Fax# 864-224-5990

Name: _____

Address: _____

Telephone: (_____)_____

Date of Birth: _____ Social Security#: _____ Patients Gender _____M _____F

Employer: _____

Employer's Address: _____

_____

Employer's Telephone: (_____)_____

In Your own words describe how the accident occurred: DATE OF ACCIDENT:_____

_____

_____

_____

_____

_____

_____

_____

Workers' Compensation Patient Statement:

I understand that if my organization's workers' compensation carrier denies the claim or if the attending physican determines that my injury is not work related, I will accept full responsibility for paying for the services rendered to me by the attending physican and staff at MED CENTRAL HEALTH RESOURCES, INC.

I hereby authorize MED CENTRAL to speak to a rehabilitation specialist, my employer, or my insurance carrier regarding my medical records and the treatment I have received or will receive.

Signature of Patient: _____Today's Date_____

OFFICE USE ONLY
Name of Person Auth. Visit:

_____

Does Employer Require a Post-Accident Drug Screen?
_____Yes_____No

Staff: