Peter Hughes, MD
526 Glen Street
Glens Falls, NY 12801
(518)792-5340

Workman's Compensation Questionnaire

Name _____ WC Claim # _____

Address _____

Date of Birth _____ Social Security # _____ Date of Injury _____

Employer _____ Employer's Phone # _____

Employer's Address _____

Comp Carrier Name _____ Carrier's Phone # _____

Carrier Address _____

ADDRESS where injury occurred: _____

How did injury occur? _____

_____

Were you hospitalized? ☐ Yes ☐ No If yes, where? _____

Were x-rays taken? ☐ Yes ☐ No

Were you previously under the care of another doctor? ☐ Yes ☐ No

If yes, please enter name: _____ Is treatment continuing? ☐ Yes ☐ No

On what date will you be able to resume regular work? _____

Are you working at the time of this treatment? ☐ Yes ☐ No

I accept financial responsibility and promise to pay for all charges billed by **Peter Hughes, MD** to this account.

_____ _____

Signature Date