Peter S. Schwartz, MD
Pediatric & Adult Ophthalmology

2333 North Triphammer Road
Suite 403
Ithaca, NY 14850

tel: (607) 266-7600
fax: (607) 266-7601

WORKER'S COMPENSATION INFORMATION FORM

NAME: TODAY'S DATE:

DATE OF BIRTH: AGE:

CURRENT ADDRESS:

HOME PHONE: SOCIAL SECURITY #:

EMPLOYER'S NAME:

EMPLOYER'S ADDRESS:

EMPLOYER'S PHONE #:

EMPLOYER'S WORKER'S COMP CARRIER:

TOWN YOU WERE WORKING IN AT THE TIME OF THE ACCIDENT:

DATE OF ACCIDENT: TIME:

PLEASE EXPLAIN IN DETAIL THE EVENTS LEADING TO THE ACCIDENT AND THE RESULTS OF THE ACCIDENT AS THEY RELATE TO YOUR VISIT HERE TODAY. PLEASE BE AS SPECIFIC AS POSSIBLE:

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS INJURY:

IF YES, BY WHOM?