



POCONO MRI

IMAGING & DIAGNOSTIC CENTER, LLC

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"For a better view of your health"

www.PoconoMriCt.com

WORKER'S COMPENSATION INTAKE FORM

Name : _____

Date of Injury: _____

What state did the accident happen in : _____

How did the injury occur (be specific) : _____

What part of the body was injured ? _____

Who is your treating Physician ? _____

Did you treat with a panel physician (this is a group of physicians posted at your place of employment)? YES or NO (Circle one)

If yes, please give name of physician _____

If you were employed in Pennsylvania, was treatment continued for 90 days? YES or NO or NOT APPLICABLE (Circle one)

Do you have a notice of compensation payable? YES or NO (circle one)

Note : If you have missed 7 days of work, worker's compensation insurance mandates that you must be provided with a Notice of Compensation payable within 21 days of the date that the employer receives notice of your disability. You may obtain this from your insurance carrier or Bureau of Worker's Compensation.

Did you bring a copy of the Notice of Compensation Payable ? YES or NO

If yes, please have receptionist make a copy for your file.

Patient's Signature

Date