WORKERS COMPENSATION BOARD
C-4 REGISTRATION SHEET – INITIAL VISIT

(to be completed by Patient)

A. Patient's Information

1. Last Name ____________________________ First Name ___________________MI ______
2. Social Security Number __________________ 3. Home Phone Number __________________
4. WCB Case # (if known) __________________ 5. Carrier Case # (if known) _______________
6. Mailing Address: ____

   City: _________________________ State: __________ Zip __________ Country: USA

7. Date of injury/onset of illness ____________ 8. Date of Birth _________ 9. Gender __M __F
10. On the date of injury/illness what was your job title or description:

    ____

11. On the date of injury/illness, what were your usual work activities?

12. Are you working now? ____Yes ____No

B. Employer Information

1. Employer when injury occurred ____
2. Employer phone number
3. Employer mailing address: ____

   City: _________________________ State: ____________ Zip __________ Country: USA

C. Billing Information

1. Employers Insurance Carrier ____
2. Carrier code number ____________________
3. Carrier Mailing Address: ____

   City: _________________________ State: ____________Zip __________ Country: USA