Workers Compensation Information

BARBOUR
PLASTIC SURGERY

Please print legibly. Leave blank if it does not apply.

Date of Injury	Date of this Visit
Name	SS#
Date of Birth Gender	Job Title
Employer Name	Employer’s Phone Number
Employer Street Address	City
State Zipcode	Workers Comp Payer Name
Claim Number	State in which the Injury Occurred
Adjustor’s Name	Adjustor’s Phone Number
Nurse Case Manager’s Name & Phone Number	Workers Comp Fax Number