Westford Internal Medicine, P.C.
Worker's Compensation

Patient Name:	**Date of Birth:**

Address: ____

City: ________________________ State: ___________ Zip: ___________________________

Phone: _______________

Date of Injury:	**Injured body part(s):**

Employer: ____

Worker's Comp. Insurance Carrier:

Address: ____

City: ________________________ State: ___________ Zip: ___________________________

Case # ______________________Phone: _______________ Fax Number: _______________

Attorney Name:

Address: ____

City: ________________________ State: ___________ Zip: ___________________________

Case # ______________________Phone: _______________ Fax Number: _______________

Assignment release: I hereby authorize my insurance benefits to be paid directly to Westford Internal Medicine. I authorize Westford Internal Medicine to release the information requested on the forms submitted on my behalf.

Signature: ____________________________ **Date:** ___________________________________