

**RICHARD HUGHES, MD ENT PC
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Richard Hughes, M.D., A.B.O., F.A.C.S.

Russ Otto, RPA-C

COMPENSATION QUESTIONNAIRE

Name: _____ WC Claim # _____

Address: _____ Patients DOB: _____

SS#: _____

Employer: _____ Insurance Carrier: _____

Employer's Address: _____ Insurance Carrier Address: _____

Employer's Phone #: _____ Insurance Carrier Phone #: _____

Date of injury: _____

Address where injury occurred: _____

How did injury occur? _____

Were you hospitalized? _____

If yes, where: _____

Were X-rays taken? _____

Were you previous under the care of another doctor? _____

If yes, please write the name: _____

Is treatment continuing? _____

On what date will you be able to resume regular work? _____

Are you working at the time of this treatment? _____

I accept financial responsibility and promise to pay for all charges billed by **Richard Hughes, MD ENT PC** to this account.

Signature: _____