Medical Claim History

RE: Employee Name:
Employer Name:
Claim Number:
Date of Injury:

For the purpose of having a complete medical history to provide your treating doctor, please complete the bottom of this sheet to the best of your ability. If you have been treated at a Kaiser Facility, please include your medical record number and the name of the physician who has treated you.

During the past 10 years, I have received medical treatment at the following:

Doctors, Hospitals Medical Plans, Chiropractors, Acupuncturist.	Address or location to the best of your knowledge.	Approximate date to the best of your knowledge.	Part of the body or type of treatment.
1.			
2.			
3.			
4.			
5.			

_____ _____

Name Date

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. I declare under penalty of perjury that the above is true and correct.