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Ophthalmology

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WORKER'S COMPENSATION REPORT

1. Name: _____ 2. Birth date: _____
3. Soc. Security No.: _____ 4. Occupation: _____
5. Employer's Name: _____
Employer's Address: _____
Type of Business: _____ Employer's Phone No. _____
6. Was your employer notified of this injury? _____ YES _____ NO
7. Name of Employer's Insurance Carrier: _____
Insurance Carrier Address: _____
Phone No.: _____ Contact Person: _____
8. Date of Injury: _____ Time of Injury: _____ AM _____ PM
9. Last Day Worked: _____
10. Location of injury (Address): _____
11. In your own words, how did injury or illness happen?

12. Were you treated by anyone else?
Name of Doctor or Facility: _____
Date Seen: _____

A STATEMENT OF UNDERSTANDING

I understand that I have the primary duty and obligation to pay my doctor for any and all services, not withholding any contract that I may have with any third party (be it insurance company, employer, union, government, or the like). It is also my understanding that if, for any reason, payment is not made within a six month period, I will assume responsibility for payment. Said payment will then be received by me from the insurance company.

Signed: _____ Date: _____

Home Address: _____

Home Phone No.: _____ Witness: _____