Thomas H. Lagen, MD
Workers Comp Specialist

email: thlmd@drlagen.com
fax: 253-514-6829
phone: 253-363-6246
PO Box 1815 | Gig Harbor, WA 98335
www.drlagen.com

Return this form to Dr. Lagen, so we can get started!
Mail: Dr. Lagen | PO Box 1815 | Gig Harbor, WA 98335
Fax: 253-363-6246
Scan or take a photo of each page and email to: thlmd@drlagen.com

Date: _____

Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Choose one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Cell phone: _____ Home phone: _____

Email: _____

Emergency Contact:

Name: _____ Best Phone: _____

Relationship: _____

Primary Care Physician:

Name: _____ Phone: _____

Insurance:

☐ State of WA Labor and Industries ☐ Self Insured Name: _____

Claim #: _____ Date of Injury: _____

Employer at time of injury: _____

Job of Injury: _____

Nature of Injury (brief description):

Thomas H. Lagen, MD
Workers Comp Specialist

email: thlmd@drlagen.com
fax: 253-514-6829
phone: 253-363-6246
PO Box 1815 | Gig Harbor, WA 98335
www.drlagen.com

Appointment Date: _____

Name: _____

Date of Injury: _____

Frequency of Pain: (circle) No Pain Occasional Pain Frequent Pain Continuous Pain

Pain Severity: (circle)

No Pain **Worst pain of my life**

0 1 2 3 4 5 6 7 8 9 10

What activities make your pain worse?

_____

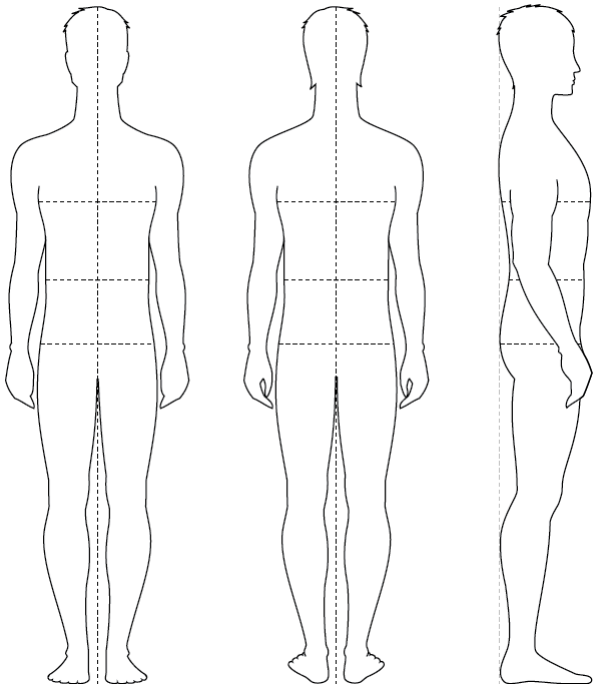
What activities make your pain better?

_____

Please indicate on the diagram, using the provided scale, the location and type of pain:

A = Aching
B = Burning
N = Numbness
P = Pins & Needles
S = Stabbing
O = Other

Height: _____
Weight: _____



Thomas H. Lagen, MD
Workers Comp Specialist

email: thlmd@drlagen.com
fax: 253-514-6829
phone: 253-363-6246
PO Box 1815 | Gig Harbor, WA 98335
www.drlagen.com

Authorization to Release Healthcare Information

Patient's Name: _____ Previous Name: _____

Date of Birth: _____ Date of Injury: _____

Claim #: _____

I request and authorize medical records of the above captioned claim to be sent to:

Thomas H. Lagen, MD
Workers Comp Specialist
PO Box 1815
Gig Harbor, WA 98335

thlmd@drlagen.com | fax: 253-514-6829
phone: 253-636-6246

This request and authorization applies to all health care information.

I understand that my express consent is required to release any health care information relating to testing, diagnoses, and/or treatment for psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnoses, testing, or treatment.

Patient's Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

This authorization will remain in effect until revoked in writing.