ORTHOPAEDIC SPECIALISTS

Better experience. Better results.

WORKER COMPENSATION INFORMATION

Date____________________ Family Physician ____________________

PATIENT INFORMATION

Name ____________________ Birthdate ____________ Social Security Number ____________________

Address ____

Home Phone ( ) ____________________ Cell Phone ( ) ____________________

Marital Status ________ Sex ________ Age _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unkonown

Occupation ____________________ Preferred Pharmacy ____________________

Employer

Employer Name ____

Employer Address ____

Employer Phone ( ) ________________ Fax Number ( ) ________________ Contact Person ________________

Injury Verified by (For office Use)____

Worker Compensation Carrier

Worker Compensation Carrier ____

Carrier Address ____

Carrier Phone ( ) ________________________ Fax Number ( ) ________________

Adjuster Name ________________________ Claim Number________________

INJURY INFORMATION

Date of Injury ____________ Time _______ ☐AM ☐PM State of Injury ☐ IA ☐ IL Other ____________

Accident Reported to employer? Yes ☐ No ☐ Name of person you reported accident to ____________________

Give full description of how accident happened ______________________________

____

____

Other doctors seen for this condition: Doctor's Name ______________________________

Diagnosis ________________________ Were X-Rays taken? ☐Yes ☐No Other Tests? ☐Yes ☐No

If yes, by whom? Please list test(s) and results(s) ______________________________

____

Any previous Worker Compensation injuries? ☐Yes ☐No Date(s) of previous injuries ____________________

Describe previous Worker Compensation Injuries ______________________________

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefit is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment charges.

________________________________ ____________

Signature of Patient, Parent, Guardian or Personal Representative Date

________________________________ ____________

Please print name of Patient, Parent, Guardian or Personal Representative Date