WORKERS COMPENSATION INFORMATION

(To be filled out at first visit for workers compensation injury)

GENERAL INFORMATION:

Patient's Name: Work Phone:

Employer Name:____

Employer Address: ____________________City:______ _____________________

Employer State: _______________________Zip:___ _________________________

WORKERS COMPENSATION INSURANCE INFORMATION:

(Information must be filled out. If not, balance will be billed to patient)

Have you reported your injury to your employer? YES ( ) NO ( )

Contact person at you employer: ___________________Phone: _________________

Workers Comp Insurance Carrier: ____

Street Address: ____

City: _____________________State: ____________Zip: _______________________

Phone: ________________WCB# _______________Carrier Case # _____________

INJURY INFORMATION:

Date of Injury: _______________________Time: _____________________

Address where injury occurred: ____

Have you been treated by anyone else?_______ If so, by who?_____________________

____

Briefly describe the accident and your injury: ________________________________

____

____

Are you out of work? YES ( ) NO ( ) Date last worked: ___________________

AUTHORIZATION
I authorize Northeast Orthopaedics to release all records pertaining to medical history, Services rendered to me (or my dependent) for insurance claims. I authorize payment of Medical benefits to Northeast Orthopaedics. I recognize that I am responsible for all payments
Not covered for the medical service disputed or denied by my insurance carrier or employers
Workers compensation carrier.

Patient's Signature: ______________________________Date: ____________________

LOCATION: **ALBANY EAST GREENBUSH DELMAR LATHAM TROY CLIFTON PARK**

Please fax completed form to 518-435-1807