Workers' compensation

To be completed at first visit for workers' compensation injury

1. General information

Patient's name | Work phone | DOB

Employer name

Employer address

City | State | Zip

2. Workers' compensation insurance information

This section must be completed. If not, balance will be billed to patient.

Have you reported your injury to your employer? ☐ Yes ☐ No

Contact person at your employer | Phone

Workers' Comp insurance carrier

Street address

City | State | Zip | Patient SS#

Phone | WCB # | Carrier case #

Adjuster Name | Adjuster phone

3. Injury information

Date of injury | Time

Address where injury occurred

Have you been treated by anyone else? ☐ Yes ☐ No If so, by whom?

Briefly describe the accident and your injury

Are you out of work? ☐ Yes ☐ No Date last worked

4. Authorization

I authorize OrthoNY 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 OrthoNY. I recognize that I am responsible for all payments not covered for the medical service disputed or denied by my insurance carrier or employer's workers' compensation carrier.

Patient's signature | Date

Please fax completed form to (518) 371-6555

FOR INTERNAL USE ONLY

ALBANY CLIFTON PARK DELMAR EAST GREENBUSH LATHAM MALTA SARATOGA

For patients to fill out prior to seeing physician

Name Date

1. Describe where and how the injury/illness occurred:

2. Describe the injury/illness and identify specifically any affected body parts:

Is it ☐ LEFT or ☐ RIGHT

3. Other treatments for the injury/illness including hospitalization or surgery:

4. Patient's complaints:

Relevant medical history, including prior treatment for a similar work-related injury/illness:

On the date of the injury/illness what was the patient's job title or description?

On the date of the injury/illness what were the patient's usual work activities?

Office use only

1. *In your opinion, was the incident that the patient described the competent medical cause of injury yes or no*
2. *Are the patient's complaints consistent with the injury/illness yes or no*
3. *Is the patient's history of the injury/illness consistent with your objective findings yes or no*
4. *What is the percentage (0-100%0 of temporary impairment*