American Orthopaedics and Sports Medicine
Workers Compensation Information

Have you been here before? **Yes** **No** If so, when? ______________________

Social Security #______________________ Primary Language______________________

Mr./Mrs./Ms.______________________ ____ ______________________

First MI Last

____

Street Address Apt./Sp. #

____

City State Zip

Home Phone (___)______________ Cell(___)______________

Date Of Birth______________ Sex **M** **F** Marital Status **S** **M** **W** **D**

Employer at the time of injury______________________

Address______________ City______________ State___ Zip______

Phone______________ Fax______________ Supervisor______________

Job Title______________ Human Resorce contact______________

Date of Injury/Illness______________ Injury time__________am/pm

Date last worked______________ When did you report the injury? ______________

To whom did you report the injury? ______________________

Where did the injury occur?______________________

List body part(s) affected/hurt ______________________

Describe how the injury happened ______________________

____

Are you working for a temp agency? **Yes** **No** If yes, who?______________

Name of work comp insurance______________________

Address______________ City______________ State_____ Zip__________

Claims Rep______________ Claim#______________ Phone#______________

Nurse case mgr______________ Phone#______________ Fax#______________

Authorizations/Remarks:

___ Eval & Treat Per______________________ Date__________

___ Eval **call** for future txmt Per______________________ Date__________

___ Med/Legal/AOE-COE Disputes?__________ Per______________ Date__________

Work status should be faxed to______________ fax#______________

Called to______________ Ph#______________

Doctor______________ appointment ______________

I hereby consent to and authorize the administration of all treatment that may be considered advisable or necessary in the judgment of the physician, and I hereby authorize American Orthopedics & Sports Medicine or contracted agents to release as determined appropriate for any lawful use without limitation, any medical information regarding the patient's history, condition, or treatment. I understand that I am entitled upon demand to a copy of this authorization. **I agree to pay the doctor's usual fees for any legal testimony or work requested by myself, my attorney or agent, or any other entity which arises from any legal action to which I am a party.**

______________________ __________ ______________

Signature of Patient Date Witness