



Orthopedic & Sports Medicine Center Worker's Compensation Information

Patient Name: _____ Account Number: _____

Employer: _____ Date of initial injury: ____/____/____

Describe injury: _____

What are your present symptoms? _____

Date you reported injury to your employer: ____/____/____

Date(s) of subsequent injuries: ____/____/____

Date(s) you missed work: ____/____/____

Names of other physicians you have seen for this injury: _____

What treatment, such as pain medication and physical or occupational therapy, have you had for this injury? _____

What is your job title? _____

Describe your duties: _____

Are you currently working? Yes No

If yes, are you on full duty? Yes No

Describe any work restrictions: _____

I acknowledge that all of the above information is true and correct and that it has been furnished to this office with full knowledge that I am liable for all said services rendered and that I am contractually bound to pay for said services. I hereby authorize Orthopedic & Sports Medicine Center, S.C., to release medical records and any related information to my employer or health insurance carrier to secure payment for services provided.

Patient or Guardian Signature

Date