ORTHOPAEDIC ASSOCIATES
OF WAUSAU S.C.

WORKER COMPENSATION INFORMATION FORM

Patient Information

Name _____ Birth date _____ SS# _____

Address _____

Telephone H _____ W _____ Occupation _____

Employer Information

Employer Name _____ Telephone _____

Address _____

Contact Person _____ Injury verified by _____

Worker Compensation Carrier

Name of Carrier _____ Telephone _____

Address _____

Claim No. _____ Person Contacted _____

Details of Injury

Date of Injury _____ Time _____

Place of Injury _____Body Part_____

Was an accident report filed with your employer? Yes ____ No ____ Who to? _____

Details of accident: _____

_____

Amount of lost time from work _____ Have you seen another physician for this condition? Y _____ N ____

Is so, Who _____ Were X-rays taken? Y ___ N____

What other tests were done? _____

_____

Authorization

I understand and do agree that all services provided to me are my financial responsibility in the event that my Insurance Carrier denies benefits.

Patient's Signature _____ Date _____