ORTHOPAEDIC ASSOCIATES OF WAUSAU

WORKER COMPENSATION INFORMATION FORM

Patient Information

Name _____ Date of Birth _____ SS# _____

Address _____ Date of Hire: _____

Telephone H/M _____ W _____ Occupation _____

Employer Information

Employer Name _____ Telephone _____

Address _____

Contact Person _____ Injury verified by _____

Worker Compensation Carrier

Name of Carrier _____ Telephone_____

Address _____

Claim Number _____ 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 ___

If 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 _____