



Orthopedics and Sports Medicine, P.A.

WORKERS COMPENSATION
PATIENT INFORMATION SHEET

NAME DATE

ADDRESS

CITY STATE ZIP CODE

HOME PHONE CELL PHONE

DATE OF BIRTH AGE SOC SEC #

MARITAL STATUS SPOUSE DATE OF BIRTH

EMERGENCY CONTACT PHONE

EMAIL ADDRESS OK TO CONTACT VIA EMAIL? Y N

NAME OF EMPLOYER

CITY WORK PHONE

NAME OF INSURANCE CARRIER:

CLAIM ADDRESS

NAME OF ADJUSTOR: PHONE:

CLAIM NUMBER: DATE OF INJURY:

REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN PHONE

ACTIVE ORTHOPAEDICS AND SPORTS MEDICINE, PA WILL BILL YOUR WORKER'S COMPENSATION CARRIER DIRECTLY FOR ALL SERVICES RENDERED PERTAINING TO YOUR WORK RELATED INJURY. ANY TREATMENTS OR SERVICES NOT APPROVED OR ARE NOT WORK RELATED WILL BE BILLED DIRECTLY TO YOUR PRIVATE HEALTHCARE INSURANCE OR TO YOU DIRECTLY.

I AUTHORIZE ACTIVE ORTHOPAEDICS AND SPORTS MEDICINE, PA TO FURNISH ANY RECORDS OF MEDICAL HISTORY FOR SERVICES RENDERED OR TREATMENT GIV EN TO ME FOR THE PURPOSE OF REVIEW OR FILING A CLAIM WITH MY INSURANCE CARRIER. IF APPLICABLE, I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLES, CO-INSURANCE, CO-PAYMENTS OR ANY PORTION OF THE BILL THAT MY INSURANCE COMPANY DOES NOT APPROVE/DENY. I UNDERSTAND THAT IF REQUIRED, A VALID REFERRAL IS DUE AT THE TIME OF SERVICE ,OTHERWISE MY APPOINTMENT WILL BE RESCHEDULED.

Signature of Patient or Responsible Party

Date