WORKMAN'S COMPENSATION PATIENT INFORMATION

NP NI FU INJ FX AC DOCTOR________ ACCT#__________

The Central Orthopedic Group, LLP PLV / RVC / MASS

DATE _______________

Patient Last name______________________**First**___________________DOB_________Age _____

Parent or Guardian (if under 18)___________________________ Contact Phone # ______________________________

Address ____________________________**City** _______________**State** _________**Zip Code** _________

Home Phone # ________________________ Work # ______________________ Cell #______________________

S.S. #__________ Male____ Female____ Employer____________________ **Email:**________________________

Referring Physician ________________________________ Address ______________________________________
Telephone #______________________________________ Fax #____
Primary care physician (if different from referring physician) ____
Address ______________________________Telephone # ______________________ Fax #__________________

BODY PART____ **RIGHT / LEFT (*CIRCLE*)**
Date of Injury_____________________________ **Duration of Problem** _____________________________________
Seen in Emergency room? YES OR NO (*CIRCLE*) Date___________________ **Name of Facility**________________
X-Rays Taken ? YES OR NO Date _________________ **Facility** ___________________________________
MRI/ CT SCAN Taken? YES OR NO Date _________________ **Facility** ___________________________________
Pharmacy Name _______________**Telephone #** _______________**Address** _______________________________

COMPENSATION INSURANCE INFORMATION

Name of Insurance Company _____________________ Address ____
Date of injury ____________ Contact Person ____________________Contact Telephone(____)__________________
Did you report your injury to your Employer? Yes ____ No ____ Are you currently working? Yes _____ No _____
Policy # _______________________ Case# __________________________ Date last worked: _________________
Name of Employer: _____________________________ Address: ____
Telephone# (_____)___________________ Contact Person: ____

PRIVATE INSURANCE INFORMATION:

Name of Insurance Company ____ Policy #______________________
Name of Policy Holder ______________________________ Relationship to Patient ______________________________
DOB of Policy Holder _______________________________ S.S. # of Policy Holder ______________________________

MEDICAL INFORMATION RELEASE

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to : The Central Orthopedic Group, LLP. I understand that I am financially responsible for treatment rendered.

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Signature of Patient or Authorized Representative: Date

GUARANTEE AGREEMENT

1. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES
   In the event that I fail to provide the Central Orthopedic Group, LLP with valid Workman's Compensation information or if it is determined by Workman's Compensation Board that the condition is not a result of a work related injury, I agree to pay for all medical services rendered to me by the Central Orthopedic Group, LLP.

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Signature of Patient or Authorized Representative: Date

UPDATED 3/2017