Workers' Compensation Registration

(please type or print)

Account Number

Complaint/Area of Body Right Left

Patient's Name
First Middle Last

Birth Date Accident Date

How did accident happen?

Employer's Name

Address Telephone

City, State, ZIP Fax
City State ZIP

Name of Workers' Comp Insurance

Address Telephone

City, State, ZIP Fax
City State ZIP

Claim Number Is your employer involved in a managed care plan?

QRC/Nurse Case Manager's Name Telephone

Fax

Are you currently being treated by another doctor for this problem? Yes No

Treating physician's name From what date?

If you have had tests done for this problem, i.e. MRI, CT Scan, X-Rays, please list them below

AUTHORIZATION AND AGREEMENT: I hereby authorize Orthopaedic Associates of Duluth, P.A. to furnish information to my workers' compensation carrier concerning my accident/illness. I understand that I am financially responsible for all charges not covered by my workers' compensation and all charges for treatment unrelated to my workers' compensation illness or injury.

Date Signature