

# 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

City

State

ZIP

Fax

Name of Workers' Comp Insurance

Address

Telephone

City, State, ZIP

City

State

ZIP

Fax

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