

Orthopedic Associates of Dayton

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WORKERS COMP INFORMATION FORM

*****THIS FORM MUST BE COMPLETED IF YOU ARE BEING SEEN FOR A WORK-RELATED INJURY*****

Patient Name: _____ Date: _____

Social Security #: _____ Date of Birth: _____

Telephone: H) _____ (C) _____

Where were you employed at when injured? _____

Employer address: _____ City, State, Zip: _____

Employer phone #: _____ HR Contact person: _____

Date of injury: _____ Do you have a claim # if so what is it: _____

Have you been able to work since injury? Yes ___ No ___

Have you completed a First Report of Injury? Yes ___ No ___ Physician of Record: Yes ___ No ___

Physician of Record: _____ Initial treatment at: _____

Managed Care Organization (MCO) or Self-Insured Company: _____

Allowed condition(s) on claim: _____

Body part injured-indicate Right or Left: _____

Please give a description of how your injury occurred: _____

Check One: ___ My on-the job accident was the one and only cause of my present condition

___ My on-the-job accident aggravated a condition that already existed prior to my accident

Private Insurance Company Information: _____

ID# _____ Grp# _____

***If you do not provide your private medical insurance information, you WILL BE BILLED for all services not covered under your WC claim.**

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Patient Signature: _____ Date: _____