

**Department of Orthopedics
WORKER'S COMPENSATION PATIENT INTAKE FORM**

Today's Date: _____ Caller's Name: _____

Provider: Dr. Bried: _____ Dr. Cohen: _____ Dr. Owsley: _____ Dr. Knutson: _____ Dr. Barba: _____ Dr. Patel: _____

Appt Date: _____ Time: _____

Visit Type: Consult Only _____ Exam & Treat _____ Second Opinion _____ Evaluation Only _____

PATIENT INFORMATION

Name: _____ DOB: ___/___/___ SS: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

Type of Injury: _____ Accepted Injury: Yes ___ Undecided ___

Claim# _____ DOI: ___/___/___ ON Interpreter Required: Yes ___ No ___

Records/Studies: Y ___ N ___

INSURANCE INFORMATION

Company: _____ Adjuster: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

UR Phone: _____ **Fax:** _____ Works Status: Phone ___ Fax: ___ Mail ___

NURSE CASE MANAGER

Name: _____ Phone: _____ Fax: _____

EMPLOYER INFORMATION

Employer: _____ Contact Name: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Form Completed By: _____ Date: _____