Orthopaedic Trauma & Fracture Specialists
Medical Corporation

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**Orthopaedic Traumatologist**
**Board Certified in Orthopaedic Surgery**

## INFORMATION FOR CASE HISTORY: WORK COMP / MED-LEGAL

☐ IME ☐ WORK COMP ☐ AOE-COE Date: _____

**Patient's Full Name:** _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Other: _____ Email: _____

Billing Address (if other than above): _____

Marital Status: _____ **Date of Birth:** _____ Age: _____ Sex: _____ **Social Security #:** ___ - ___ - ___

Current Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred By: _____ Part of the body affected: _____ Right ☐ Left ☐

How long have you had symptoms? _____ **Date last worked:** _____

Did your symptoms follow an injury? _____ How did it occur? _____

Where did it occur? On the job? ☐ Home ☐ Auto ☐ Other _____ **Date of injury:** _____

**Work Comp Carrier:** _____ Telephone: _____ **Fax:** _____

Address: _____ City: _____ State: _____ Zip: _____

Claims Examiner: _____ **Claim #:** _____

Case Manager: _____ Telephone: _____

**Employer at time of the injury**: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Private Party Responsibility: _____ Claim#: _____

Address: _____ City: _____ State: _____ Zip: _____

**Plaintiff's Attorney**: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

**Defense Attorney**: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

**Emergency Contact:** _____ Telephone: _____

Have you ever been seen in this practice before? Yes ☐ No ☐ By: _____ When: _____

**I understand that patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid, I promise to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. If my account has to be referred for outside collection I will be charged a service charge. AUTHORIZATION: I hereby authorize payment directly to Orthopaedic Trauma & Fracture Specialists Medical Corporation for medical services by that entity, and to release any information acquired in the course of my examination or treatment to my insurance company.**

Patient's/Guardian's Signature **X** _____ Witness Signature _____