Orthopaedic Trauma & Fracture Specialists
Medical Corporation

3750 Convoy Street, Suite 101
San Diego, CA 92111

Tel: 858-278-8031
Fax: 858-278-1708

Orthopaedic Traumatologists
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 ______________________