St.Charles Orthopedics

WORKERS' COMPENSATION REGISTRATION

Referring Physician:_____
Referring Physician Phone#:_____

1. Carrier Case#:_____ WCB#:_____

2. Last Name:_____ First Name:_____

3. Social Security#: _____Date of Birth: _____ Gender: M F

4. Street Address: _____ City: _____

5. State: _____ Zip: _____ Home Phone#: _____

6. Cell Phone#: _____

7. Date of Injury/onset of illness: _____ Body Part: _____

8. On the date of injury/illness what was the patient's job title: _____

9. Briefly describe how and where injury occurred: _____

_____

10. Are you presently working? Yes____ No____ If 'No' when did you stop?_____
If 'Yes', are you on Regular Duty? _____ Light Duty?_____

If you stopped, when did you return? _____

11. Employer at time of injury:_____
Employer Address:_____ City:_____
State:_____ Zip:_____ Employer Phone:_____
Contact:_____

12. Employer's WC Insurance Carrier: _____
Carrier Address: _____ City: _____ State: _____
Zip:_____ Adjuster Name: _____ Adjuster Phone#:
_____

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay (Physician Name) _____ the usual and customary fees for services rendered to the above claimant. I authorize the provider to release any information necessary to substantiate a claim.
Signature: _____ Date: _____
Rev. 2/21/11