NYSI
ORTHOPEDIC DIVISION

WORKER'S COMPENSATION INFORMATION

Patient Name _____ Date of Birth _____

Telephone (____) _____ Social Security Number _____

Employer's Name _____

Employer's Address _____

Contact Person/Manager _____ Phone Number (___) _____

Date of Injury/Accident _____/_____/_____ State in which the injury occurred _____

On that date, what was your job title _____

On the date of injury, describe your usual work activity _____

_____

WORKER'S COMPENSATION INSURANCE INFORMATION

Worker's Compensation Carrier _____

Address of Carrier _____

WCB Case # _____ Carrier Case # _____

Adjuster _____ Phone Number (_____) _____

Describe how your injury occurred and what you injured

_____

_____

Have you lost time from work? Yes _____ No _____ If Yes, How Long _____

Are you working now Yes _____ No _____ Last Day Worked _____

What is your current work status (Please check one)

Regular _____ Light Duty _____ Not Working Due to Injury _____

Have you seen another doctor for this injury Yes _____ No _____

If yes, please provide name and phone number

Physician Name _____ Phone Number (_____) _____

WORKERS'S COMPENSATION – NEW PATIENT

ACCOUNT # _____

Date of Visit _____

Name _____ Date of Birth _____/_____/_____

Treating Physician

_____Salvatore Corso, MD _____ Jeffrey Guttman, MD

Treatments Requested

□ Physical Therapy □ Occupational Therapy □ Massage Therapy □ Acupuncture

□ Diagnostic - □ MRI □ CT □ EMG □ Other _____

□ Visco Injections

□ Surgery _____

□ Other _____

What is the current percentage of impairment _____%

Current Work Status

Regular _____ Light Duty _____ Not Working Due to Injury _____

Anticipated return to work date ____/____/____ Limitations _____