New York
Orthopaedic & Comprehensive
Medical Services, P.C.

A **NYSI** Affiliate

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: ______________________________

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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

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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 ☐ Dr. Teresa Bianchi, DO

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: __________ % Anticipated return to work date: ____________

Current work status. (Please check one). ☐ Regular ☐ Light Duty ☐ Not Working Due to Injury

Limitations: ______________________________

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