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: _____

_____

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: _____

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WORKERS'S COMPENSATION – NEW PATIENT

Account #: _____ Date of Visit: _____

Name: _____ Date of Birth: _____

Treating Physician

☐ Dr. Alexios Apazidis ☐ Dylon O'Rourke, PA

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: _____

_____