SPORTS & ORTHOPEDIC SPECIALISTS

WORKER'S COMPENSATION REGISTRATION FORM

PATIENT NAME

Last:	First:	DOB:

PATIENT ADDRESS

Street:		
City	State	Zip Code

PATIENT CONTACT INFORMATION:

Email Address:	Phone:

PATIENT EMPLOYMENT INFORMATION for WORKER COMPENSATION CLAIM

Employer:	Employer Phone No:

INSURANCE INFORMATION:

Worker Compensation Insurance Carrier:	Claim No:	
Address for Claim Submission: Street	City, State	Zip Code
Adjustor's Name	Adjustor's Phone No.:	Authorization Date

MEDICAL INFORMATION

Primary Diagnosis:	Date of Injury:

REFERRING PHYSICIAN INFORMATION

Name:	Phone No.:	Fax No:

RELEASE OF INFORMATION

I, the undersigned, certify that the above information is correct to the best of my knowledge. I hereby authorize Sports and Orthopedic Specialists (SOS) to release all information necessary to secure payment of benefits. I understand that I am not personally liable for any payments to Sports and Orthopedic Specialists for physical therapy services provided for this Worker's Compensation claim.

_____ _____

Patient Signature **Date**