PALOMAR HEALTH Medical Group

Department of Orthopedics
WORKER'S COMPENSATION PATIENT INTAKE FORM

Today's Date:_____ Caller's Name:_____

Provider: Dr. Bried:☐ Dr. Cohen:☐ Dr. Owsley: ☐ Dr. Knutson: ☐ Dr. Barba:☐ Dr. Patel:☐

Appt Date:_____ Time:_____

Visit Type: Consult Only☐ Exam & Treat☐ Second Opinion☐ Evaluation Only☐

PATIENT INFORMATION

Name:_____ DOB:____/____/____ SS: _____

Address:_____ City_____ State:_____ Zip:_____

Phone: (H)_____ (W)_____ (C)_____

Email:_____

Type of Injury: _____ Accepted Injury:Yes☐ Undecided☐

Claim#_____ DOI: ___/___/___ ON Interpreter Required: Yes☐ No☐

Records/Studies: Y☐ N☐

INSURANCE INFORMATION

Company:_____ Adjuster:_____

Address:_____ City_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

UR Phone:_____ **Fax**:_____ Works Status: Phone☐ Fax:☐ Mail☐

NURSE CASE MANAGER

Name:_____ Phone:_____ Fax:_____

EMPLOYER INFORMATION

Employer:_____ Contact Name:_____

Address:_____ City_____ State:_____ Zip:_____

Phone: (H)_____ (W)_____ (C)_____

Form Completed By:_____ Date:_____