

**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: \_\_\_\_\_