LONG ISLAND PODIATRY GROUP, P.C.

MEDICINE AND SURGERY OF THE FOOT

Board Certified by the American Board of Podiatric Surgery
Fellows, American College of Foot & Ankle Surgeons
Members, American Association of Diabetes Educators
www.LIpodgrp.com

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WORKERS COMPENSATION INITIAL SHEET

PATIENT NAME: _____ SS#: _____

DATE OF ACCIDENT: _____ BODY PART: _____

WHERE DID THE ACCIDENT HAPPEN? _____

_____

DESCRIBE HOW THE ACCIDENT OCCURRED: _____

_____

_____

HAVE YOU BEEN SEEN BY ANOTHER DOCTOR/HOSPITAL? (CHECK ONE): YES _____ NO _____

IF YES, WHO?: _____

WHEN?: _____

HAVE YOU FILED AN ACCIDENT REPORT? (CHECK ONE): YES _____ NO _____

ARE YOU WORKING? (CHECK ONE): YES _____ NO _____

IF **NO**, WHAT DATE DID YOU STOP WORKING?: _____

WHAT DATE DID YOU RETURN?: _____

IF **YES**, ARE YOU ON REGULAR DUTY OR LIGHT/PARTIAL DUTY?: _____

EMPLOYER AT THE TIME OF INJURY: _____

JOB TITLE: _____

ADDRESS: _____

EMPLOYER PHONE#: _____ CONTACT PERSON: _____

EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER: _____

CARRIER ADDRESS: _____

ADJUSTOR NAME: _____ ADJUSTOR PHONE #: _____

CARRIER CASE#: _____ WCB #: _____

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION, OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE, I HEREBY AGREE TO DR. _____ THE USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT. I AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION NECESSARY TO SUBSTANTIATE A CLAIM.

PATIENT'S SIGNATURE: _____ DATE: _____