SOS SYRACUSE ORTHOPEDIC SPECIALISTS

WORKER'S COMPENSATION PRE-REGISTRATION FORM

Welcome to SOS! We will offer you our best medical opinion, the best orthopedic treatment, secure the diagnostic testing you need and provide you with a treatment plan that will help lead you back to a normal life.

Please be advised that failure to provide this information at the time of your appointment or within 24 hours will result in billing you directly. We may be required to contact your employer for additional information regarding your claim, if necessary.

PATIENT INFORMATION:

Name: _____

DOB: _____ SS# (required for WC): _____

Employer at Time of Injury: _____

Address: _____

City: _____ State: _____

Phone#: _____ Contact: _____

WORKER'S COMPENSATION INFORMATION:

Worker's Compensation Insurance Carrier: _____

Address: _____ Phone #: _____

City: _____ State: _____

Date of Injury: _____ Claim #: _____ WCB #: _____

Body Part(s) Injured: _____ Please circle: Left / Right / Bilateral

WORK DESCRIPTION AT TIME OF INJURY:

List your primary tasks in a usual work day _____

_____

If you return after today, we ask that you bring in a copy of your job description and inquire with your employer if light duty work is available. Thank you.

Patient Signature: _____ Date: _____

Syracuse Orthopedic Specialists Worker's Compensation Patient Information Phone # (315) 251-3155

New York State Workers Compensation Board Phone # (866) 802-3730