SYRACUSE ORTHOPEDIC SPECIALISTS

WORKERS 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. We need you to provide us the information below at the time of your appointment or within 48 hours thereafter. If we do not receive all information, we will need to bill your private insurance for any services rendered or you will be as a "self-pay" status and ultimately be responsible for the fees incurred. Please go to our website sosbones.com under *Patient Information*, *Workers Compensation* and *Workers Compensation Notice* for more helpful details.

PATIENT INFORMATION:

Have you had previous treatment for this injury? Yes/Where: _____ No_____

Name: _____ DOB: _____ SS# (required for w/c):_____

Employer at the time of injury: _____

Address: _____City: _____ State: _____

Employer Contact Name/Phone #: _____

WORKERS COMPENSATION INFORMATION:

Worker's Compensation Insurance Carrier: _____

Address: _____ City: _____ State: _____

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

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

WORK DESCRIPTION AT TIME OF INJURY:

List your primary tasks in a usual work day: _____

_____

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

Patient Signature: _____ Date: _____

Syracuse Orthopedic Specialists, PC Worker Compensation Patient Information Line: 315.251.3155

New York State Workers Compensation Board #: 1.866.802.3730