WORKERS COMPENSATION / IME INFORMATION

Chart#_____ Appt Date/Time: _____Office _____ MD_____

Patient Name _____ ____ _____

Patient Address _____

Home Phone: _____ **Date of Birth:** _____ **SSN#** _____

Email Address: _____ **Translator Needed?** ☐ Yes ☐ No

Employer _____

Employer Address: _____

_____

Employer Phone #: _____

W/C Carrier _____ **What Network?** _____

W/C Address _____

W/C Phone # _____ **Fax#** _____

Adjusters Name: _____

Adjuster Telephone # _____ **Ext.** _____

Adj/NCM Email _____

Date of Accident: _____/_____/_____ **Claim Number**_____

Type of Injury _____

Nurse Case Managers Name: _____

Phone #_____ **Fax #**_____

Is Patient Represented by An Attorney? _____Yes ____ No If yes, who? _____

PT_____ MRI_____ # OF DR=S_____ SX_____ OLD INJURY _____ INJECTIONS_____ X-RAYS _____
MEDICAL RECORDS _____

☐ **Evaluation only** ☐ **Evaluation and treatment** ☐ **Second Opinion**

CPT CODE: _____, _____, _____ TOTAL AMOUNT OF VISIT $_____

INITIALS_____DATE_____

Updated: 20 January 2015