Date ____________

Sports Medicine & Spine Center, P.C.

Board Certified Orthopaedics

WORKER'S COMPENSATION NEW PATIENT APPOINTMENT SCHEDULING FORM

Patient's Name ____________ SS# ____________

Address ____________

Home Phone ____________ Work Phone ____________ Date of Birth ____________

Place of Employment ____________

Work Address ____________

Contact Person ____________ Contact Person and Extension ____________

Chief Complaint ____________ LT ☐ RT ☐

☐ Yes ☐ No Was one of our Doctors chosen from a panel

☐ Yes ☐ No Is this due to an injury? ***Date of injury*** ____________

☐ Yes ☐ No If so, was this an on the job injury?

Brief outline of treatment to date:

Current work status ____________

Purpose for referral (e.g. IME, 2nd opinion, Impairment Rating, Record Review):

____

Worker's Compensation Carrier Billing Information **Claim #** ____________

Carrier ____________

Address ____________

City/State ____________ Zip ____________

Adjuster ____________ Fax ____________

Phone # ____________ Ext # ____________ Email Address ____________

☐ Yes ☐ No Has patient seen another doctor? Prior Surgery ____________ If yes, please send records.

Doctor Name ____________ Phone No. ____________

X-Rays to bring? ____________ Prior Diagnostic test ____________ If yes, please send records.

******After initial office visit – your point of contact for progress notes, surgery scheduling, questions******

Dr. Bonatz - Gina

Dr. Blum - Blake

Dr. Kirchner - Emily

Dr. Talbert - Brittany

Dr. Heck - Tay

Dr. Sudduth - Brittany

Dr. Krauss - Sherrie

Dr. Smith - Loren J

For office use only: Date of Approval ____________ Appointment Date ____________ Appointment Time ____________

Please fax form to Sam Talley at (205) 972-8785 or email to stalley@slortho.com

Must have approval from adjuster or case manager.

WORKMANS COMP - SOUTHLAKE ORTHO #87987_ 8/2018