Date _____

Southlake Orthopaedics

WORKER'S COMPENSATION NEW PATIENT APPOINTMENT SCHEDULING FORM

Patient's Name _____ DOB _____ SSN _____

Home Phone _____ Cell _____ Email _____

Address _____

Place of Employment _____

Work Address _____

Contact Person _____ Phone/Ext _____

Chief Complaint LT ☐ RT ☐ _____

Date of Injury _____ ☐ Yes ☐ No Was one of our Doctors chosen from a panel?

☐ Yes ☐ No Is this due to an injury?

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

Brief outline of treatment to date:

Purpose for Referral: ☐ Evaluate and Treat ☐ 2nd Opinion ☐ Impairment Rating ☐ Record Review ☐ IME ☐ Other: _____

Current Work Status _____

Worker's Compensation Carrier Billing Information

Carrier _____ Claim Number _____

Address _____

City/State/Zip _____

Adjuster Name _____ Adj must attend appointment ☐ Yes ☐ No

Phone _____ Fax _____ Email _____

Case Manager Name ☐ N/A _____ CM must attend appointment ☐ Yes ☐ No

Phone _____ Fax _____ Email _____

Has patient seen another doctor? ☐ Yes ☐ No Has patient had prior surgery? ☐ Yes ☐ No If yes, please send records.

Physician Name(s) _____

X-Rays to bring? ☐ Yes ☐ No Prior diagnostic testing ☐ Yes ☐ No If yes, type of test _____

If yes to any of the above, please send records and ensure the patient has a copy of imaging to bring in order to avoid rescheduling.

☐ Dr. Michael Blum
☐ Dr. George R. Booker
☐ Dr Ekkehard Bonatz
☐ Dr. Beau Grantier
☐ Dr. William Craig
☐ Dr. Michael Ellerbusch
☐ Dr. Christopher Heck
☐ Dr. Dewey H. Jones
☐ Dr. John S. Kirchner
☐ Dr. William Krauss
☐ Dr. Michael Smith
☐ Dr. William Sudduth
☐ Dr. Charles J. Talbert

For office use only: Date of Approval _____ Appointment Date/Time/Location _____

PLEASE ATTACH ALL MEDICAL RECORDS & JOB DESCRIPTION. FAX FORM TO (205)449-4261 OR EMAIL TO WORKCOMP@SLORTHO.COM