



Southlake Orthopaedics

Sports Medicine and Spine Center

Date _____

a division of **SOA**

WORKERS' 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 _____

Workers' 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. William Craig

☐ Dr. Dewey H. Jones

☐ Dr. Adam Lukasiewicz

☐ Dr. George R. Booker

☐ Dr. Michael Ellerbusch

☐ Dr. John S. Kirchner

☐ Dr. Michael Smith

☐ Dr Ekkehard Bonatz

☐ Dr. Christopher Heck

☐ Dr. William Krauss

☐ Dr. Jonathon Whitehead

☐ Dr. Beau Grantier

☐ Dr. Jonathan Isbell

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
DIRECT TELEPHONE # 205-329-7582**