NYSMI NEW YORK SPORTS MEDICINE INSTITUTE

Orthopedic Surgery | Physical Therapy | Concussion Care

WORKERS COMPENSATION INFORMATION

NAME: _____

ADDRESS: _____

Home Phone: _____ Social Security: _____

Employer Name: _____

Address: _____

Contact Person: _____ Phone: _____

Date of Injury / Accident: _____

Address of where injury/accident occurred: _____

Name of Insurance Carrier: _____

Address: _____

_____

Phone: _____ Contact Person: _____

Policy #: _____ Carrier Case#: _____

Described how injury occurred: _____

_____

Have you lost time from work? No _____ Yes _____ How Long? _____

Are you working now? Yes _____ No _____ Last date worked: _____

Have you seen another doctor for this injury? No _____ Yes _____

If yes – please provide his name and phone number

Name: _____Phone _____

PLEASE NOTE: Should the insurance company refuse to accept this claims as a Worker's Compensation case, I do understand that I am fully responsible for my medical bill at the physician's normal fee.

Patient/Guardian Signature: _____ _____Date:_____

New York Sports Medicine Institute | Orthopedic Surgery

Neil S Roth MD *Gregory Galano MD* *Lisa Nason MD* *Major Angela Gagliardi MD*

Lenox Hill Hospital, 130 East 77th Street, 8th Floor - Black Hall Phone: 212-861-2300 Fax: 212-861-2442

222 N. Westchester Avenue, Suite 308, White Plains, NY 10604 Phone: 914-290-4370 Fax: 914-290-4372

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ACCIDENT REPORT FORM

Patient Name: _____ Accident Date: _____

Were you hurt on the job? _____ Yes _____No

Were you in a car accident? _____ Yes _____ No

Insurance Company Name: _____

Address: _____City:_____State: _____Zip:_____

Accident Description: Please describe the accident, place of occurrence – including city and state, whether or not you went to the hospital. Also describe your injuries.

Please list the names of doctors who have treated you for this injury. List their names, specialty, date first consulted, the treatment provided.

The information completed above is true to the best of my recollection. I understand that this information may be requested by the insurance carrier and authorize such release.

Signature of Patient/Parent/Guardian _____

Date completed: _____

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