



**Orthopedic & Sports Medicine Institute of Las Vegas
RANDA BASCHARON, D.O., INC.**

WORKMAN'S COMPENSATION INJURY

WE MUST HAVE COMPLETE AND ACCURATE INFORMATION IN ALL SECTIONS!

(PLEASE ASK FOR ASSISTANCE WITH PHONE BOOKS, OR PHONE CALLS IF NEEDED FOR ADDRESSES AND PHONE NUMBERS.)

HOW WERE YOU REFERRED TO OUR OFFICE?

- OTHER PHYSICIAN: FIRST NAME _____ LAST NAME _____ ADDR _____ CITY _____ STATE _____
- URGENT CARE / EMERG ROOM: NAME OF FACILITY _____ ADDR _____ CITY _____ STATE _____
- INSURANCE COMPANY REFERRED: NAME OF INS CO _____ AUTH# _____ REPRESENTATIVE NAME _____
- FRIEND OR RELATIVE: FIRST NAME _____ LAST NAME _____ Are they patients in this practice? YES NO

PATIENT: LAST NAME _____ FIRST _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: (____) _____ CELL PH: (____) _____ OTHER PH: (____) _____

SSN _____ SEX: MALE FEMALE DATE OF BIRTH: ____/____/____ AGE _____

EMAIL ADDRESS _____ DO YOU AGREE TO RECEIVE NEWSLETTERS AND

CORRESPONDENCE FROM OUR OFFICE VIA EMAIL? YES NO

NAME OF EMPLOYER AT TIME OF INJURY _____ DEPT: _____

EMPLOYER (AT TIME OF INJURY)

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE #: (____) _____

DATE OF INJURY ____/____/____ DATE LAST WORKED FOR THIS EMPLOYER: ____/____/____

BODY PART/S INVOLVED RIGHT LEFT _____

EXPLAIN HOW INJURY OCCURRED _____

NEW INJURY:

DID YOU/HAVE YOU, REPORTED THE INJURY TO YOUR SUPERVISOR? YES NO

IF YES, SUPERVISORS NAME: _____ DATE REPORTED ____/____/____

DO YOU HAVE A COMPLETED C-4 FORM? YES NO

OLD INJURY : HAVE YOU SEEN ANOTHER PHYSICIAN FOR THIS INJURY? YES NO

NAME OF DR: _____

ADDR _____ CITY _____ STATE _____ ZIP _____

IS THIS PHYSICIAN YOUR *CURRENT TREATING PHYSICIAN? YES NO IF NO, LIST NAME OF CURRENT TREATING PHYSICIAN

NAME OF DR: _____

ADDR _____ CITY _____ STATE _____ ZIP _____

WHAT IS THE REASON YOU ARE SEEING US TODAY? ANOTHER OPINION? CHANGE IN TREATING DR?

OTHER REASON : EXPLAIN _____

INSURANCE:

NAME OF CLAIMS ADMINISTRATOR: (INDUSTRIAL INS CO) _____

ADDRESS:(TO MAIL CLAIMS) _____ CITY _____ STATE _____ ZIP _____

CLAIM# _____ ADJUSTORS NAME: _____ PH(____) _____ EXT # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits or attorney settlement payments to be paid directly to O orthopedic & Sports Medicine Institute of Las Vegas, Dr. Randa Bascharon D.O., Inc. I understand that I am financially responsible for any balance. I also authorize Orthopedic & Sports Medicine Institute of Las Vegas, Dr. Randa Bascharon D.O., Inc. or insurance company or attorney to release any information required to process my claims.

PATIENT OR GUARDIAN SIGNATURE

DATE