



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, Urgent Care / Emerg Room, Insurance Company Referred, Friend or Relative. Includes fields for name, address, city, state, and insurance details.

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 / / MO / DAY / / YR DATE LAST WORKED FOR THIS EMPLOYER: / / MO / DAY / / YR

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 / / MO / DAY / / YR

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.

X

PATIENT OR GUARDIAN SIGNATURE

DATE