

*** This form must be completed if being seen for a workers compensation injury.**

Far Oaks Orthopedists, Inc.

WORKERS COMPENSATION INJURY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

EMPLOYER AT THE TIME THE PATIENT
WAS INJURED: _____

EMPLOYER ADDRESS: _____

CITY, STATE: _____ ZIP: _____

PHONE: () _____

CONTACT PERSON AT EMPLOYER: _____

HAVE YOU BEEN ABLE TO WORK SINCE YOUR INJURY?
IF NO, THE LAST DAY WORKED: _____

DATE OF INJURY: _____

HAVE YOU COMPLETED A BUREAU OF WORKERS COMPENSATION FIRST REPORT OF INJURY REPORT?
 YES NO IF NO, PLEASE ASK THE RECEPTIONIST FOR THE FORM TO COMPLETE
AND LEAVE WITH US.

MCO – MANAGED CARE ORGANIZATION: _____

CLAIM NUMBER: _____

BODY PART AFFECTED: _____

DESCRIBE WHAT HAPPENED: _____

DESCRIBE YOU JOB DUTIES: _____

- CHECK ONE:
- MY ON-THE-JOB ACCIDENT WAS THE ONE AND ONLY CAUSE OF MY PRESENT CONDITION.
 - MY ON-THE-JOB ACCIDENT AGGRAVATED A CONDITION WHICH ALREADY EXISTED BEFORE MY ACCIDENT.

SIGNATURE OF PATIENT

A copy of your private insurance card is needed for your file. It will only be used if your workers compensation claim is denied. If your private insurance carrier requires you to get a referral from your primary care physician to see a specialist, you should inform your primary care physician and ask that your chart be noted so if your workers compensation claim is denied you can obtain a referral.