



SPORTS MEDICINE · REHABILITATION · IMAGING

Dear Patient:

Please fill out the information requested on this form completely and accurately to ensure timely filling of claims to be submitted by our office.

Patient Name: _____ Birth Date: _____

Employer: _____ Work Telephone: _____

Email Address: _____

Street Address City State Zip Code

Employer's Workers' Compensation Carrier: _____

Street Address City State Zip Code

Claim Number: _____

Worker's Compensation Telephone No _____

Date & Time of Accident: _____

Where did the accident happen? _____

In your words, how did the accident happen? _____

Was an incident report filed at your work? _____

Name of supervisor or person handling injury claim: _____

Following the accident, did you seek any medical attention? Yes No

Where: _____

When: _____

Whom: _____

I have completed this form to the best of my knowledge. I understand that Excel Orthopedics, Ltd. will bill my Workers' Compensation carrier for this injury. However, if my Workers' Compensation carrier denies the claim, I understand that I am responsible for the balance.

Patient Signature: _____ Date: _____