SOUTHERN WESTCHESTER ORTHOPEDICS & SPORTS MEDICINE ASSOCIATES, P.C.
970 NORTH BROADWAY-SUITE 204
YONKERS, NEW YORK 10701
TELEPHONE: (914) 476-4343
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CHARLES W. EDELSON, M.D., F.A.A.O.S.
DAVID E. LENT, M.D., F.A.A.O.S.
ERIC M. SPENCER, M.D., F.A.A.O.S.
JAMES JOSEPH, M.D., MS

WORKER'S COMPENSATION

DATE: ____________________

NAME: ______________________________ DOB: ____________ SOC. SEC. # ____________
ADDRESS: ____
CITY: ______________________________ STATE: __________ ZIP CODE: ____________
HOME PHONE: ______________ CELL PHONE: ____________ OFFICE PHONE: ____________
EMAIL: ____
NAME AND PHONE OF PHARMACY: ____

EMPLOYER

EMPLOYER NAME: ____
EMPLOYER ADDRESS: ____
EMPLOYER TELEPHONE: ______________________ OCCUPATION: ____________________
HUMAN RESOURCE'S NAM EAND NUMBER: ______________________________________

WORKER'S COMPENSATION CARRIER

WORKER'S COMPENSATION CARRIER: ____
CARRIER ADDRESS: ____
CARRIER PHONE NUMBER: ____________________ FAX NUMBER: ____________________
ADJUSTOR'S NAME: _________________________ CLAIM NUMBER: __________________
W.C.B. CASE #: ______________________

INJURY INFORMATION

DATE OF INJURY: ____________________ ACCIDENT REPORTED: ____________________
PLACE OF INJURY: ____

PLEASE GIVE FULL DESCRIPTION OF HOW ACCIDENT HAPPENED:

____

____

WHAT BODY PART WAS INJURED? RIGHT _______________ LEFT ____________________
HAVE YOU LOST TIME FROM WORK? _______________ LAST DAY WORKED: ____________
ARE YOU WORKING AS OF TODAY? ____

PATIENT SIGNATURE: __________________________________ DATE: ______________

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In the event that I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation Case. I, ______________________________, hereby agree to pay The Southern Westchester Orthopedic & Sports Medicine, Assoc, P.C. 970 North Broadway, Suite 204, Yonkers, New York their usual and customary fees for services rendered to the above named claimant in the above identified case. I also authorize release of any medical information to my Primary Care Physician and/or insurance company. I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'S Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

SIGNATURE: ______________________________________ DATE: ____________________