PLEASE OBTAIN INFORMATION AT TIME THE APPOINTMENT IS MADE AND FAX TO THE BILLING OFFICE. THE APPOINTMENT CAN NOT BE CONFIRMED WITHOUT THE COMPLETED FORM FROM BILLING.

WORKER'S COMPENSATION PRE-REGISTRATION FORM

INFO TAKEN BY: ______________ ACCT#___________ LOCATION __________

APPOINTMENT DATE: ___/___/___ REFERRED BY DR: ____________________

PATIENT NAME: (F) ______________________(L)______________________________

M or F (Circle) DATE OF BIRTH_____________ DATE OF ACCIDENT__________

TEL#: ________________DAY PH #: ________________ SOC SEC# ________________

PROBLEM OR BODY PART: _________________________ MRI: ___YES ___NO

EMPLOYER'S NAME: _______________________ TELEPHONE #: _________________

CARRIER NAME: __________________________ TELEPHONE #: _________________

ADDRESS: ____

CLAIM #: __________________________WCB#:________________________________

CONFIRMATION FROM INSURANCE DEPARTMENT:

AS PER CARRIER (SPOKE WITH _________________________), THE FOLLOWING INFORMATION WAS CONFIRMED:

BODILY INJURY OR INJURIES WERE REPORTED UNDER THIS CARRIER CASE NUMBER:

__________________________________.

AUTHORIZED TO BE TREATED FOR: ______________________ WITH NO RESTRICTIONS.

PATIENT CAN BE SEEN UNDER THIS CASE NUMBER WITH THE FOLLOWING RESTRICTIONS:

____.

THIS CASE WAS CLOSED ON _____/_____/_____ FOR ORTHOPEDIC TREATMENT. PATIENT MUST PAY OR HAVE OTHER APPROPRIATE INSURANCE.

BILLING COMMENTS:____

____

WORKER'S COMPENSATION REGISTRATION

PATIENT NAME (LAST, FIRST, M.I.) ____________________
ADDRESS ____________ CITY ____________ STATE ____ ZIP ______
DATE OF BIRTH ___/___/___ SOCIAL SECURITY # ____________
HOME # ____________ SEX: M __ F __ MARITAL STATUS: S __ M __ D __ S __
EMPLOYER ____________ ADDRESS ____________
WORK # ____________ OCCUPATION ____________
REFERRING PHYSICIAN ____________ TELEPHONE # ____________

WAS ACCIDENT REPORTED AT WORK? YES______ NO______
TO WHOM DID YOU REPORT YOUR ACCIDENT(Give name & title, if known)____________
WHAT TOWN OR CITY DID INJURY OCCUR____________
DID THEY REPORT IT TO THEIR CARRIER? YES______ NO______
DATE AND TIME OF ACCIDENT:____________ INJURED BODY PART:____________
HAVE YOU EVER INJURED THIS BODY PART BEFORE? YES / NO IF YES, PLEASE
EXPLAIN:____________
WORKER'S COMP CARRIER: ____________
CARRIER'S ADDRESS: ____________
CASE MANAGER NAME and PHONE NUMBER ____________

WCB# ____________ **CARRIER CASE #** ____________

EMPLOYER NAME and **ADDRESS** at the time **THIS INJURY OCCURRED:** ____________
____

EMPLOYER PHONE NUMBER:____________

ARE YOU PRESENTLY WORKING? YES / NO IF NO, WHEN DID YOU STOP WORKING?__________
IF YES(CHECK) ARE YOU ON **REGULAR DUTY?** _____**LIGHTY DUTY**_____
DATE RETURNED TO WORK:____________

LEGAL
WILL AN ATTORNEY BE CONTACTING US? YES ___ NO ___
IF, YES HIS/HER NAME and ADDRESS: ____________
____

IN CASE OF AN EMERGENCY PLEASE CONTACT:
NAME ____________ TELEPHONE # ____________

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by 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 ____________, M.D> his usual and customary fees for services rendered to the above named claimant in the above identified case. I authorize the provider to release any information necessary to substantiate a claim.

SIGNATURE (IF MINOR, PARENT SIGNATURE)____________ DATE:__________

If signed by other than claimant, print below: **Name, Address and relationship to signer.**

Name and Address:____________

Relationship to Patient: ____________

Checked by:__________ **Date:**__________

PLEASE FILL OUT PAGES 1 – 2 – 3

PLEASE PRINT

DATE: ____/____/____

HOME#: ________________________ WORK#: ______________________________

PATIENT'S NAME: ____________________________________ AGE: ____________

REFERRING DR: ______________________________ PHONE#: ________________

ADDRESS: ____

LIST IN ORDER YOUR MAIN COMPLAINTS:

1. ____
2. ____
3. ____

WHEN PROBLEMS STARTED: ____

HOW: ____

IS LITIGATION INVOLVED? (Y) (N) ____

DETAIL YOUR PROGRESS TO DATE: ____

____

DETAIL YOUR TREATMENT TO DATE IN ORDER: ______________________________

____

PAST HISTORY: OPERATIONS: ____

MEDICAL ILLNESSES: ____

____

DRUG ALLERGIES: ____

LIST CURRENT MEDICATIONS: ____

FAMILY ILLNESSES (PARENTS, ETC.): _______________________________________

TYPE OF WORK/RECREATION: ____

DO/DID YOU SMOKE? (Y) (N) IF YES, HOW MUCH? ________ HOW LONG? ________

DO YOU DRINK ALCOHOL? (Y) (N) IF YES, HOW MUCH? ____________________

MARITAL STATUS: MARRIED SINGLE DIVORCED OTHER ______________

DO YOU HAVE ANY OF THE FOLLOWING CONDITITONS?

______________	STOMACH PROBLEMS	______________	CANCER
______________	DIABETES	______________	HEART
______________	ARTHRITIS	______________	EPILEPSY
______________	GOUT	______________	WEIGHT LOSS
______________	SEXUAL DIFFICULTIES	______________	WEIGHT GAIN
______________	BOWEL/BLADDER	______________	BLEEDING
______________	THYROID	______________	HEPATITIS
______________	FEVER/NIGHT SWEATS	______________	HIV

OTHER PLEASE EXPAIN ____

DO YOU HAVE ANY COMPLAINTS WITH REFERENCE TO YOUR:

APPETITE _____HEAD_____EYES_____EARS_____NOSE____HEART/LUNGS____ KIDNEYS_____

FEMALE PATIENTS: DATE OF LAST MENSTRUAL PERIOD/MENOPAUSE: _____/_____/_____

ARE YOU CURRENTLY BREAST FEEDING? YES NO

ANY POSSIBILITY OF PREGNANCY? YES NO

ANY PROBLEMS WITH YOUR JOINTS?

HIPS___KNEES____ANKLES____FEET____SHOULDERS____ELBOWS___WRISTS___HANDS___

WERE X-RAYS TAKEN? YES NO IF SO, WHERE/WHEN ______________________

PLEASE CIRCLE THE DIAGNOSTIC TEST(S) YOU HAVE HAD:

CT SCAN MYELOGRAM DISCOGRAM MRI EMG BONE SCAN DATE: ___/____/___

NAME AND TELEPHONE OF FACILITY: ______________________________

DO YOU PLAN TO BE AT YOUR REGULAR JOB IN SIX MONTHS? YES NO

HAVE YOU EVER BEEN INCAPACITATE AND UNABLE TO WORK? YES NO

IF YES, FROM _____/_____/_____ TO _____/_____/_____

NAME/ADDRESS OF ATTORNEY YOU WOULD LIKE YOUR REPORTS SENT TO: ____________

____.

PATIENTS SIGNATURE: ______________________________________

IRA CHERNOFF, M.D.
MARC CHERNOFF, M.D.
ARJEN KEUSKAMP, M.D
Stony Brook Medical Park
2500 Nesconset Hwy
Building #20
Stony Brook, NY 11790
(631)246-6100

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. INCLUDE ALL AFFECTED AREAS.

ACHE ^^^^	NUMBNESS 0000	PINS & NEEDLES ====	BURNING XXXX	STABBING ////
^^^^	0000	====	XXXX	////
^^^^	0000	====	XXXX	////