Prairie

Prairie Orthopaedic & Plastic Surgery, PC
www.prairie-ortho.com

WORKMAN'S COMPENSATION INFORMATION

Today's date: _____

Patient Name: _____

Patient Social Security Number _____

Date of injury or loss _____

Briefly describe injury (left knee, right hand, etc.) _____

_____

Has this injury been reported to Workman's comp. (OR) has an injury report been filled out at your workplace?

_____

Employer (Insured) _____

Address _____

_____

Work Comp. Carrier _____

Address _____

_____

_____

Claim Number: _____

Name of Adjuster: _____

Phone Number: _____

Fax Number: _____

I authorize Prairie Orthopaedic & Plastic Surgery, to release my medical records to my employer, their insurance agents and representatives (e.g. Case manager, rehabilitation counselor)

Patient signature _____

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