WORKERS' COMPENSATION AND MEDICAL/LEGAL REGISTRATION

Appointment Date ________________ Time ________________

AME DQME AQME Reevaluation ________________ Consultation (explain) ________________

PATIENT INFORMATION

Name ____ M F Age _______ DOB ______________

Address ____

Home Tel (_____) _______________ Work Tel (_____) _______________ Other (_____) _____________

Occupation ____ SSN _________________________

Area(s) Injured ____

Employer (at date of injury) ____

Employer's Address ____

EMERGENCY-CONTACT INFORMATION

Emergency Contact #1 ____ Relationship ________________

Address ____

Home Tel (_____) _______________ Work Tel (_____) _______________ Other (_____) _____________

Emergency Contact #2 ____ Relationship ________________

Address ____

Home Tel (_____) _______________ Work Tel (_____) _______________ Other (_____) _____________

INSURANCE INFORMATION

Insurance Company ______________________________________ Adjuster ________________________

Address ____

Tel (_____) ________________ Fax (_____) ________________ Set by __________________________

Claim Number ______________________________ Nurse Case Manager ___________________________

Date(s) of Injury ____

APPLICANT ATTORNEY

Law Firm____

Name of Attorney ____

Address ____

Tel (_____) ________________ Fax (_____) ________________

INTERPRETER

Interpreter needed? Yes No

Patient signature ____ Date _________________________

ASSIGNMENT OF BENEFITS

I hereby assign medical and/or surgical payments—including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan—to Nicholas Colyvas, M.D., for services he provides. This assignment shall remain in effect until I submit a written revocation to him. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the foregoing information to secure payment. A copy of this assignment shall be as valid as the original.

Patient signature ____ Date ________________________

Nicholas Colyvas, M.D., Inc.

Orthopaedic Surgery and Sports Medicine

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Questionnaire for Patients

Please fill out this questionnaire as completely as you can. This will assist in making your orthopaedic consultation as simple and effective as possible.

Name ____

Yourself

What is your age? _____________

What is your height? _____________

What is your weight? _____________

Are you left-handed, or right-handed? L R

Your work

Who was your employer at the time of the injury? ___________________________________

What is/was your job title at that company? ____

Are you still working there? ____

If so, how long have you worked there? ____

If not, how long did you work there? ____

When was your last day of work? ____

Your injury

On what date were you injured? ____

Which part of your body was injured? ____

Where were you first treated? ____

Have you seen any other specialists? ____

Have you had X-rays, MRIs, or other studies? _______________________________________

Has this part of your body had an injury or problem prior to this? _____________________

If yes, please describe the injury or problem briefly: ________________________________

____

At the present time

Are you still working? ____

Are you taking medication for the injury or problem? ________________________________

If you have had physical therapy, are you still in physical therapy? ____________________

Have you had surgery for the injury? ____

Are you getting better, getting worse, or staying the same? ___________________________

Your medical history

Other medical problems: ____

Prior surgery(ies): ____

Medications: ____

Are you a smoker, or a nonsmoker? ____

Allergies, if any: ____

Patient signature _____________________________________ Date __________________