PENNSYLVANIA ORTHOPAEDIC CENTER

WORKERS' COMPENSATION REGISTRATION

PATIENT INFORMATION

Patient Name:______________________________

Address:______________________________

City:______________ State:________ Zip Code:______________

Telephone #: (Home)______________(Work)______________

EMPLOYER INFORMATION

Employer Name:______________________________

Address:______________________________

City:______________ State:________ Zip Code:______________

Telephone #:______________ Supervisor:______________

WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Carrier:______________________________

Address:______________________________

City:______________ State:________ Zip Code:______________

Telephone #:______________ Adjuster's Name:______________

Claim #:______________ Date of Injury:______________

Do you have an occupational injury report? ______Yes ______No

I understand that I am personally responsible to provide PAOC/Ruggiero Orthopaedic Associates, Ltd. with my Workers' Compensation insurance information and claim number related to my injury and understand that by not providing the required information that I may be denied treatment.

I understand that if my workers' compensation claim is deemed to be "not work related" or to be an "invalid claim": (1) I am personally responsible for payment of all unpaid claims made by PAOC/Ruggiero Orthopaedic Assoc., Ltd. (2) If my personal insurance requires me to obtain referrals for medical treatment, I am responsible to obtain all applicable referrals for services provided by PAOC/Ruggiero Orthopaedic Assoc., Ltd.

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Patient Signature Date