Workers Compensation Information

Name:______________________________ Date and time of Injury: _______________

City/Town where injury occurred: ____

WCB Case No.: ____________________ Carrier Case No: _____________________

Employer Name/Address & Phone: ____

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Comp Insurance Carrier: ____

Carrier Address/Phone: ____

What orthopaedic problem are we treating today: ______________________________

Other injuries sustained with this date of accident that we are not treating at this time____

State how injury occurred: ____

Was this an already existing injury?____

Have you seen another doctor for this injury? **Yes or No**
If yes, Whom?____

Are you working now? **Yes or No**

First day missed from work:______________1st day returned to work:______________

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR I F COMPENSATION CLIAM IS DISALLOWED

In the event I fail to prosecute the claim for workers' compensation for this illness or condition it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I, ___________, hereby agree to pay Lake Placid Sports Medicine, PLLC, PO Box 790, 29 Church Street, Lake Placid, NY 12946, their usual and customary fees for services rendered to the above named claimant in the above identified case.

Signature: ____________________________ Date: _______________________

If signed by other than claimant, print below: name, address, and relationship of signer.

____ ____________________________

Name and Address Relationship

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