HMP Orthopedics, P.C.
Richard E. Pearl, M.D.
50 East 77TH St., Apt 1C
New York, NY 10075

Workers' compensation

To be completed at first visit for workers' compensation injury

1. General information

Patient's name | Work phone | DOB

Employer name

Employer address

City | State | Zip

2. Workers' compensation insurance information

This section must be completed. If not, balance will be billed to patient.

Have you reported your injury to your employer? ☐ Yes ☐ No

Contact person at your employer | Phone

Workers' Comp insurance carrier

Street address

City | State | Zip | Patient SS#

Phone | WCB # | Carrier case #

Adjuster Name | Adjuster phone

3. Injury information

Date of injury | Time

Address where injury occurred

Have you been treated by anyone else? ☐ Yes ☐ No If so, by whom?

Briefly describe the accident and your injury

Are you out of work? ☐ Yes ☐ No Date last worked

4. Authorization

I authorize OrthoNY to release all records pertaining to medical history, services rendered to me (or my dependent) for insurance claims. I authorize payment of medical benefits to OrthoNY. I recognize that I am responsible for all payments not covered for the medical service disputed or denied by my insurance carrier or employer's workers' compensation carrier.

Patient's signature | Date

Please fax completed form to (518) 371-6555

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