RICHARD S. OBEDIAN, M.D., F.A.A.O.S., PLLC

WORKERS' COMPENSATION INFORMATION

Name:_____
Address:_____
_____
SS No._____

Home Phone:_____
Work Phone:_____

Date of Injury:_____

Exact location of Injury:_____
_____
Employer:_____
Address:_____
_____
Phone No._____

WORKERS' COMPENSATION INSURANCE CARRIER
Ins. Co. Name_____
Adjuster's Name / # _____
Address:_____
_____
Telephone No._____
Fax No._____
WCB No._____
Carrier Case No._____

Have you reported this injury to your employer? YES NO

Are you working now?_____

List all body parts that were related to this work injury. Specify right and left.

_____

Briefly describe how work injury occurred:_____
_____

Please fill in the following if applicable:
Attorney's Name:_____
Firm's Name:_____
Address:_____
_____
Phone No._____

"I verify the accuracy of the above information and I authorize the release of information as provided on this form. I also authorize the assignment of benefits directly to Richard S. Obedian, M.D., PLLC. I understand that I am financially responsible for the treatment rendered. I hereby authorize Richard S. Obedian, M.D., PLLC to submit a claim to the insurance carrier or its intermediaries for all covered services rendered for radiology and orthopaedic care and authorize and direct the insurance carrier or its intermediaries to issue payment check(s) directly to Richard S. Obedian, M.D., PLLC."

SIGNATURE_____ **DATE**_____