URGENT ORTHOPEDIC SPECIALISTS

4304 Andrews Hwy
Midland TX 79703
432-520-3020 bus 432-699-1981 fax
ssanchez@orthomidland.com

Work Related Verification form

*This form must be completed in its **entirety and a complete set of medical records** must be received **with referral,** before an appointment will be made. A copy of Twcc 73 and dictation will be sent to treating doctor and adjustor approximately 2-3 days after the patient is seen.*

TREATING DR: ______________________________ PHONE # ______________________________

ADDRESS ______________________________ FAX# ______________________________

******WE WILL NOT ASSUME THE ROLE OF TREATING PHYSICIAN******

PT NAME: ______________________________ MARRIED______ SINGLE________

SS# ______________________ DOB______________________ MALE________ FEMALE________

ADDRESS____

HOME PH______________________________ CELL______________________________

EMPLOYER______________________________ WK PH______________________________

ADDRESS____

CONTACT PERSON______________________________ PH # ______________________________

W/COMP CARRIER______________________________ DOI______________________________

ADDRESS____

ADJUSTOR PH# ______________________________ FAX # ______________________________

ADJUSTOR______________________________ CLAIM #______________________________

BODY PART(S) INJURED____

HOW INJURY OCCURRED ____

OFFICE USE ONLY

SPOKE TO______________________________ ANY DISPUTES______________________________

PAY @ CHECK OUT__________ BILL TO EMPLOYER: ________________ CARRIER: ________________

BODY PART AUTHORIZED? ____

DENIED______________ APPROVED______________ APPT DATE______________________ TIME__________

NOTES____

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