WORKERS COMPENSATION VISIT REQUEST

Initial Appointment scheduled for:___________________@_____________with:

John P. Kendrick, M.D.
James R. Goss, D.O.
Eric Stiefel, M.D.
Travis Bailey, D.O.

Oscar E. Aguero Jr., M.D.
Charles W. Sanderlin Jr., M.D.
Paul Lane Jr., M.D.
Ibrahim Usman-Oyowe, M.D.

J. Eric Gee, M.D.
Michael Clark, M.D.
Justine Cowart, M.D.

Chart #:___________

Patient Name:____ DOB:______________

Home/Mailing Address:____

City:_____________________ State:_________ Zip:____________________________

Phone:____________________________ Alt. Phone:_____________________________

New Patient_____ IME_____ Take over care_____ 2nd Opinion_____ 2nd Opinion/opt. TX_____

All case types EXCEPT **New Patient** require an invoice be sent and paid prior to scheduling appt

DOI: _____ SSN: ____________ Injured area(s):____

Employer: _________________________________Phone:______________________________

Address: __________________________City:_______________State:_____Zip:_____________

Brief Description of Injury/Accident & Treatment Received:

Has patient been seen by another non-ortho doctor? Y N Orthopedic? Y N

If yes, who? __________________ Where? __________________

Was the patient seen at the local E.R.? Y N If yes: SGMC Smith

Has the patient had x-rays? Y N MRI? Y N Where? _________________
Remind them that the patient must bring a copy of all radiology not done at OMRI, SGMC, or Smith

Claim #_____________________ W/C INS Company: _____________________

Billing Address:_____________________ City:_____________ State:_______ Zip:___________

Adjustor:_______________________ Phone:__________________ Fax:____________________

Are we authorized to take x-rays in office: Y N Can we provide DME: Y N Limit: $

Do they accept the GA fee schedule? Y N Can we provide medications? Y N