ORTHOPEDIC CENTER
of Palm Beach County

Workers Compensation Registration/Authorization Form **Chart#**_____

Date: _____ Intake Person: _____ Date of Injury (DOI): _____

Physician: _____ Appointment Date: _____ Time: _____ LW ☐ BB ☐ WELL ☐

Patient Name: _____ Sex: M _____ F _____

Date of Birth (DOB): _____ Social Security (SS#): _____ - _____ - _____

Home #: _____ Work #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Body Part: _____

Translator Needed: Yes No Requested **W/C Claim Number:** _____

Employer at time of injury: _____

Address: _____

City: _____State: _____Zip: _____Phone # _____

Referral Source: _____**(i.e. Liberty, Summit, Corvel, etc…)**

NCM/Adjuster/Employer: _____

Phone # _____ Ext:_____ Fax # _____

Email: _____

NCM/Adjustor/Employer:_____

Phone # _____ Ext:_____Fax # _____

Email: _____

*****Billing Information*****

Insurance Company:

_____

Address: _____

Attorney Name: **Carrier / Patient**_____

Phone # _____ Fax # _____

Address: _____

Email:_____