

GENESEE ORTHOPAEDICS AND SPORTS MEDICINE, LLP

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Workers' Compensation Information Form

Please provide the following information in order to properly bill for your care. It is necessary that you bring this information with you to your first appointment. If this information is not provided at the time of your visit, you will be billed for all visits.

Patient's Name _____

Employer's Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Name of Employer's Workers' Compensation Carrier:

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Fax Number _____

Date of injury _____

Describe your job _____

Describe how the injury occurred _____

Workers' Compensation Claim # _____

Please verify with your employer that an accident report (C-2) has been filed with their Worker's Compensation Carrier.