Parkcrest Orthopedics, LLC
Specialists in Upper & Lower Extremities

Name:_____ Date of birth:_____

WORKERS' COMPENSATION QUESTIONNAIRE

This form must be completed by *all* patients.

You must answer ALL of the following questions!

1. What **body part** are you being seen for today? Please specify left or right side.

   _____

2. Do you have an open Workers' Compensation claim? (circle one)

   YES NO

3. ***If you circled YES to question 2:***
   Does the open work comp claim pertain to the above body part? (circle one)

   YES NO

4. ***If you circled NO to question 2*:**
   I do not intend to file workman's comp claim for the above listed body part/injury at this time or at any point in the future. I understand that if for any reason my medical insurance does not cover the charges of my appointment/treatment that *I will be responsible for any and all charges incurred.* _____ (**please initial on the line)**

By signing below, I am stating that all of the above information is accurate to the best of my knowledge.

X_____

Signature of Patient Date

If this is an open Worker's Compensation claim and an attorney is involved, you must have the attorney contact us to set up an Independent Medical Evaluation which they will be responsible for paying for. We will not be able to see you for an office visit. If you feel that your injury or condition is work related but denied by your employer and/or Work Comp carrier, we will need a copy of the denial letter from them. If your case has been closed or settled, we will need a copy of this letter in order to submit to your group medical insurance.

James P. Emanuel MD • Glen E. Johnson MD • Richard Johnston MD • Micah C. Hobbs DO
Phone: 314-997-1777 • Fax: 314-997-6277
845 N. New Ballas Ct. • Suite 130 • Creve Coeur, MO 63141