1061

REFERRING OR PRIMARY PHYSICIAN INFORMATION (So that we may mail a copy of your visit):

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

WORK COMP INFO (Please skip this section if not work related):

W/C Carrier: _____

W/C Claims Address: _____

City, State, Zip: _____

Claims Adjuster: _____

Phone Number: _____

Fax Number: _____

Employer: _____

Phone Number: _____

Address: _____

Claim #: _____

Date of Injury: _____

Nurse Case Manager: _____

Phone Number: _____

Fax Number: _____

ATTORNEY INFO:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Primary Treating Physician: _____

Address: _____

City, State, Zip: _____

Secondary Treating Physician: _____

Address: _____

City, State, Zip: _____

☐ Consultation Only ☐ 2nd Opinion Only ☐ Evaluation/Treatment

AUTHORIZED TO TREAT: ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Other: _____

☐ INFORMED TO BRING FILMS ☐ INFORMED TO BRING INTERPRETER

USC ORTHOPAEDIC SURGERY
SURGERY INTAKE FORM

PATIENT ID

KH-USC

DOB:
DOS:
ATT:
REF:
MRN:
FIN:

WHITE - MEDICAL RECORDS