GENESEE ORTHOPAEDICS AND SPORTS MEDICINE, LLP
33 Chandler Ave
Batavia, NY 14020
Phone 585-343-9676
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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.