



Oklahoma Center for Orthopaedic & Sports Medicine
M. Sean O'Brien, D.O.

WORKER'S COMPENSATION

Patient: _____ DOB _____ SS# _____

Patient Address: _____
Street City State Zip

Home Phone: _____ Mobile/Cell _____

Employer: _____ Employer Phone: _____

Employer Address: _____
Street City State Zip

Are you claiming this as an on the job injury? ___Yes ___No **Date of Injury:** _____

What type of injury? _____ How did it occur? _____

Has your employer been informed of the injury? ___Yes ___No Supervisor: _____

Work Comp Company _____

Work Comp Address _____
Street City State Zip

Contact Person: _____ Phone #: _____ Fax #: _____

Nurse Case Manager: _____ Phone #: _____ Fax #: _____

Claim Number _____ Verified By _____

If yes, are you receiving compensation? ___Yes ___No

Do you have an attorney? ___Yes ___No if yes, who _____

Were you referred to our office? ___Yes ___No if yes, who _____

Have you been treated by any other Doctor for this injury? ___Yes ___No

If yes, who _____ Phone Number _____

Doctor Name: _____ Appointment: _____ Scheduled by: _____
