

## Understanding Workers Compensation & Alpha Neurology's Services

We all understand that Workers Compensation laws are designed to ensure that employees who are injured or disabled on the job are provided with wage replacement and medical and rehabilitation benefits. However these services are limited to the **specific part of the body that was injured** on the job and that is not always clear.

When a Workers Compensation case is established, a "**body part injury**" is also established. As a result of this a physician is **allowed to treat that established body part only** and submit his charges to the Workers Compensation Board for payment for his services. In turn the Workers Compensation Board will authorize payment for that treatment as long as it is for the part of the body that was designated as injured on the job.

While the Providers at Alpha Neurology believe in treating the whole patient, we are severely limited as to what Workers Compensation will reimburse our practice for.

Hopefully this will help our patients understand our limits. The following pages need to be completed, in full, in order for us to begin your treatment.

We all dislike filling out forms; however the more information we have when you enter our office, the quicker you will be seen and the better we are prepared to serve you.

# Alpha Neurology PC – Workers Compensation Information

Last Name	First Name	Middle Name	Date of Birth	Sex
Address		Social Security Number		
City	State	Zip code	Cell Phone	Home Phone
Referring Physician or Provider Name		Address	Phone Number	
Date of Injury / /	Time of injury AM PM	Address, including State where injury occurred-		

Retained Lawyer's Name, Address and telephone number:

Occupation	Describe your usual activities on the day of your injury:
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Describe your injury and how it occurred

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name, Address and Phone Number \_\_\_\_\_  
 \_\_\_\_\_

Do you have a history of same or similar condition?  Yes  No If yes, state when and describe below:

\_\_\_\_\_  
\_\_\_\_\_

Enter Employer's Name and Address when Injury Occurred \_\_\_\_\_

Phone Number      Employer Contact Name

## ENTER WORKERS COMPENSATION INSURANCE INFORMATION

Insurance Name

Insurance Address      City      State      Zip code

Policy Number      Insurance Case Number      WCB Case Number

Claim Adjusters Name      Insurance Phone Number

## ENTER YOUR COMMERCIAL INSURANCE INFORMATION (ex: GHI, Cigna, Aetna, Medicare)

Insurance Name

Insurance address      City      State      Zip code

Insurance ID Number      Insurance Phone Number

# Alpha Neurology PC

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

<p><b>Statistics:</b>  <input type="text"/> Height _____  <input type="text"/> Weight _____</p> <p><b>Current Medications:</b>  <input type="text"/>  <input type="text"/>  <input type="text"/>  <input type="text"/>  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> Dizziness  <input type="checkbox"/> Vertigo  <input type="checkbox"/> Memory loss  <input type="checkbox"/> Disorientation  <input type="checkbox"/> Speech or language dysfunction  <input type="checkbox"/> Inability to concentrate  <input type="checkbox"/> Seizures  <input type="checkbox"/> Taste, smell or touch disturbance  <input type="checkbox"/> Headache  <input type="checkbox"/> Migraine headache  <input type="checkbox"/> Numbness or Tingling  <input type="checkbox"/> General weakness  <input type="checkbox"/> Muscle weakness  <input type="checkbox"/> Slurred Speech  <input type="checkbox"/> Blurred vision  <input type="checkbox"/> Loss of consciousness  <input type="checkbox"/> Balance problems  <input type="checkbox"/> Falls  <input type="checkbox"/> Depression  <input type="checkbox"/> Fatigue  <input type="checkbox"/> Neck pain  <input type="checkbox"/> Back pain</p> <p><b>CONSTITUTIONAL</b></p> <p><input type="checkbox"/> Fatigue (sluggish, tired)  <input type="checkbox"/> Weight loss  <input type="checkbox"/> Weight gain  <input type="checkbox"/> Weight stable  <input type="checkbox"/> Night Sweats  <input type="checkbox"/> All negative</p>	<p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Muscle cramping  <input type="checkbox"/> twitching or pain  <input type="checkbox"/> Joint swelling  <input type="checkbox"/> Joint stiffness  <input type="checkbox"/> Joint pain  <input type="checkbox"/> Noise with joint movement  <input type="checkbox"/> Arm or leg pain  <input type="checkbox"/> All negative</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Itching  <input type="checkbox"/> Scars  <input type="checkbox"/> Moles or lesions  <input type="checkbox"/> Changes in color of moles or lesions  <input type="checkbox"/> Rashes  <input type="checkbox"/> All negative</p> <p><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> Anxiety  <input type="checkbox"/> sleep disturbance  <input type="checkbox"/> Hallucinations  <input type="checkbox"/> All negative</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> Palpations  <input type="checkbox"/> Heart Murmur  <input type="checkbox"/> Irregular pulse  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> Swelling  <input type="checkbox"/> Coldness/numbness in fingers or toes  <input type="checkbox"/> All negative</p> <p><b>EYES</b></p> <p><input type="checkbox"/> Itching  <input type="checkbox"/> Excessive tearing  <input type="checkbox"/> Double vision  <input type="checkbox"/> Light sensitivity  <input type="checkbox"/> All negative</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Difficulty breathing  <input type="checkbox"/> Chronic cough  <input type="checkbox"/> Asthma  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> All negative</p>	<p><b>GENITOURINARY</b></p> <p><input type="checkbox"/> Painful urination  <input type="checkbox"/> Frequent Urination  <input type="checkbox"/> Night urination  <input type="checkbox"/> Unable to control urination  <input type="checkbox"/> All negative</p> <p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Diabetes  <input type="checkbox"/> Adrenal problems  <input type="checkbox"/> Changes in height or weight  <input type="checkbox"/> Increased appetite  <input type="checkbox"/> Increased thirst  <input type="checkbox"/> Hair change/loss  <input type="checkbox"/> All negative</p> <p><b>HEMATOLOGIC/LYMPHATIC</b></p> <p><input type="checkbox"/> Anemia  <input type="checkbox"/> Bleeding tendencies  <input type="checkbox"/> Easy bruising  <input type="checkbox"/> Fatigue  <input type="checkbox"/> Recurrent infections  <input type="checkbox"/> Slow healing from cuts  <input type="checkbox"/> All negative</p> <p><b>ALLERGIC/IMMUNOLOGIC</b></p> <p><input type="checkbox"/> Hay fever  <input type="checkbox"/> Itching  <input type="checkbox"/> Sneezing  <input type="checkbox"/> Chronic clear nasal drainage  <input type="checkbox"/> Conjunctivitis  <input type="checkbox"/> Allergies to Medication  <input type="checkbox"/> All negative</p> <p><b>ENMT</b></p> <p><input type="checkbox"/> Sensitivity to noise  <input type="checkbox"/> Ear Pain  <input type="checkbox"/> Ringing in the ear  <input type="checkbox"/> Nosebleeds  <input type="checkbox"/> Sinusitis  <input type="checkbox"/> Vertigo  <input type="checkbox"/> Post nasal drip  <input type="checkbox"/> Bleeding gums  <input type="checkbox"/> Hoarseness  <input type="checkbox"/> Difficulty Swallowing  <input type="checkbox"/> All negative</p>
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Patient Signature \_\_\_\_\_

HealthCare Provider Signature \_\_\_\_\_

# Alpha Neurology PC

Name \_\_\_\_\_ Date \_\_\_\_\_

**PAST Medical History:** Have you been diagnosed with any of the following?

Heart Disease       Parkinson's disease       Neuropathy       Lupus       Obesity  
 Coronary Artery Disease       Multiple Sclerosis       Stroke       Gout       COPD/Emphysema  
 Diabetes Mellitus       Pacemaker       Rheumatoid Arthritis       Carpal Tunnel       High Cholesterol  
Other \_\_\_\_\_

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Previous Surgeries \_\_\_\_\_

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**Family History:**

	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke	<input type="checkbox"/>					
Seizure	<input type="checkbox"/>					
Multiple Sclerosis	<input type="checkbox"/>					
Parkinson's Disease	<input type="checkbox"/>					
Migraine Headache	<input type="checkbox"/>					
Neuropathy	<input type="checkbox"/>					
Heart Disease	<input type="checkbox"/>					
Respiratory Disease	<input type="checkbox"/>					
Cancer	<input type="checkbox"/>					
Psychiatric Disorder	<input type="checkbox"/>					
Sudden, unexplained death	<input type="checkbox"/>					

**Social History:**

Smoking:       Yes, how many packs per day? \_\_\_\_\_       No, never       Quit, when \_\_\_\_\_

Alcohol Use:       Daily       Socially

Recreational Drug use:       Yes       No

Employment:       Employed       Part Time       Unemployed       Retired

Marital Status:       Single       Married/Cohabitating       Divorced/Separated       Widowed

Have you, or a close family member or friend recently suffered any emotional stress: such as losing a job, a divorce, moving to a new location? If yes, please explain \_\_\_\_\_

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**If a Physician referred you to our office, please  
list his/her name or list a Physician's name you  
would like us to send a report to.**

**Dr's Name** \_\_\_\_\_

**Address** \_\_\_\_\_

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Patient Signature

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Reviewing Physician's Signature