Urgent Injury Clinic

WORKERS' COMPENSATION FORM

RETURN TO FAX (515) 221-6566 EMAIL workcomp@dmos.com

DMOS® ORTHOPAEDIC CENTERS

EMPLOYEE

First name | Last name | Today's date

Date of birth | Address | City, State, Zip

Date of incident | Diagnosis

Description of injury or accident

Yes ☐ **No** ☐ Is there a pre-existing condition that is contributing to the injury?

If yes, please explain: _____

Yes ☐ **No** ☐ Has the employee previously seen another physician for this conditions?

If yes, please provide:

Physician name | Practice | Dates of service

Physician address | Physician City, State, Zip

Physician phone | Physician fax

List any testing that has been done for this condition

Pharmacy preference

AUTHORIZATION TO TREAT

EMPLOYER

Employer name | Contact first name | Contact last name

Employer address | Employer City, State, Zip

Employer phone | Employer fax

INSURANCE

Insurance carrier name | Adjuster

Insurer address | Insurer City, State, Zip

Insurer phone | Insurer fax | Claim number

Authorized representative's signature | Printed name | Title