STUART D. KATCHIS, M.D.
130 East 77th Street 12 Floor
New York, New York 10075
(212) 434-4920
Fax (212) 434-4887

WORKER'S COMPENSATION INFORMATION

Patient's Name (Print): _____

Social Security # _____ Date of Injury: _____

State how injury occurred: _____

_____

_____

MUST FILL OUT, DON'T LEAVE BLANK (if you do not have the information please obtain it)

Name of Insurance Company: _____

Address: _____

City, State, Zip: _____

Telephone: _____

WCB Case# _____ Carrier Case# _____

Employer: _____

Address: _____

City, State, Zip: _____

Telephone: _____

Are you presently working? Yes or No

Date returned to work: _____ Date last worked: _____

Case Worker's Name: _____

Case Worker's Phone Number: _____ Fax: _____

Have you been treated by any other physician? Yes or No

If Yes:

Physician's Name:_____

Address: _____

City, State, Zip: _____

Telephone: _____

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case I _____, hereby agree to pay Dr. Stuart Katchis the usual and customary fee(s) for services rendered to me.