



ILLINOIS BONE AND JOINT INSTITUTE, L.L.C. LAKE SHORE ORTHOPAEDICS
350 SOUTH GREENLEAF AVE., STE 405, GURNEE, IL 60031
900 NORTH WESTMORELAND RD., LL-72, LAKE FOREST, IL 60045

**PLEASE COMPLETE and FAX TO:
WORKERS' COMPENSATION DEPARTMENT
Fax: 847-693-2191 — Phone: 847-596-7621**

WORKERS' COMPENSATION INTAKE FORM

Patient Name: _____ DOB: _____ DOI: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____ Fax #: _____

W/C Insurance Carrier: _____

Attn: _____

W/C Insurance Address: _____

W/C Insurance #: _____ Fax #: _____

W/C Claim #: _____

W/C Adjuster: _____

Nurse Case Manager: _____

Type of Injury AND Body Part Injured: _____

Send Claims To:

W/C Insurance / Employer / Adjuster / Nurse Case Manager
(Please Circle All That Apply)

Send Progress / Work Status Reports:

W/C Insurance / Employer / Adjuster / Nurse Case Manager
(Please Circle All That Apply)

Additional Information / Comments: _____

FOR OFFICE USE ONLY:

Verified by Employer: (name) _____ Verified by W/C Carrier: (name) _____

Verified at LSO by: _____ Date Verified _____ ACCT # P: _____

Appointment Date / Time: _____ Doctor: _____