Dr. Michael Bollinger, MD
Dr. Bruce Bragonier, MD

WORK COMP PATIENT INFORMATION Date of Visit______________

Please print legibly

Name Last, First Middle______________________________ Gender ☐ Male ☐ Female

Mailing Address______________________ City______________State____ Zip_________

Email ______________________Home Phone______________ Cell______________

Preferred method of contact – check all that apply: ☐ Home Phone ☐ Cell Phone ☐ email

Date of Birth______________ SS#______________ Drive License______________

I hereby consent to the release of protected health information to the following individuals. I understand this authorization will be in effect until I personally revoke it.

Name	Relationship
______________________	______________________
______________________	______________________

Occupation______________ Employer______________ Phone#______________

Emergency Contact Name______________________ Relationship______________

Emergency Contact Phone (Home#)______________ (Cell#)______________

Referring Physician Name______________________ Phone#______________

Primary Care Physician ______________________ Phone#______________

Preferred Language ______________ Race ______________ Ethnicity ______________

Are you currently in a Skilled Nursing Facility? ☐ Yes ☐ No Name of Facility______________

Employer At Time Of Injury Company Name______________________

Address______________________ City______________State_________ Zip_________

Company Contact ______________________ Phone#______________

Workers Comp Information Workers Comp Company______________________

Address______________________ City______________ State_________ Zip_________

Adjustor Name______________________ Phone______________ Fax______________

Claim ID#______________ Date of Injury ______________ Body Part(s) Injured ______________

Have you retained an attorney? ☐ Yes ☐ No Attorney name______________Phone#______________

Over for page 2

Page 2 Patient Name____

Please note: Our Physicians will not act as, nor accept Primary Care Physician status for any Worker's Compensation patients.

FEES FOR FORMS: The following forms will cost the patient $15.00 for our staff to complete. EDD Forms (CA State Disability), FMLA, Union paperwork, Aflack insurance forms, Medical verification report for child support, PG&E forms, other miscellaneous Medical forms and letters written by the doctor (for medical insurance qualification, travel cancellation, etc).

SURGERY FEES: All co-pays, deductibles and payment for non-covered surgical procedures are due prior to your scheduled surgery. **Please Note: Your carrier may require prior authorization for office visits and/or surgery.**

AUTHORIZATIONS:

I, ____ HEREBY AUTHORIZE PAYMENT OF MEDICAL AND/OR SURGICAL BENEFITS TO MICHAEL T. BOLLINGER, MD OR BRUCE R. BRAGONIER, MD. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I FURTHER AGREE TO BE FINANCIALLY RESPONSIBLE TO PAY FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY. I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS OR INFORMATIOHN NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

I, ____ HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS OR INFORMATION TO MY PRIMARY CARE PHYSICIAN AND/OR SPECIALIST WHEN NECESSARY FOR FURTHER TREATMENT.

Signature____ Date______________________________