Tesson Heights Orthopaedics Disability Form

Failure To Complete ALL Of This Form Could Delay Your Benefits.
Please Allow 5 to 7 Days for Processing.

TODAY'S DATE: ____________________

PATIENT'S NAME: ____

PHYSICIAN SEEN (Please circle one.):

1) **Dr. Benz**
2) **Dr. Fagan**
3) **Dr. Markenson**
4) **Dr. Lee**
5) **Dr. Zippay**

DATE OF INJURY: ____

FIRST DAY OFF WORK: ____

ESTIMATED RETURN DATE OF WORK: __________________________

PLEASE CHECK ONE:

☐ **MAIL FORM TO COMPANY**

☐ **MAIL FORM TO PATIENT (address same as in patient's chart)**

OTHER ADDRESS: ____

☐ **FAX FORM TO: #**____

☐ **CALL PATIENT TO PICKUP: #** ____

☐ **PERSON TO CONTACT FOR QUESTIONS:** __________________________________

Received By ____

COMMENTS: ____

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