

Disability Intake Form



Patient Name: _____ Today's Date: _____

Date of Surgery: _____ Dr.: Steren/Barter/Young/Levav/Snyder

Surgery to Be Performed: _____

Expected Return to Work Date: _____

- Please return form to me by _____
- (1) I will come by to pick up.
 - (2) Mail to me at this address _____

 - (3) Fax to me _____ Fax # _____
 - (4) Mail to other address _____

 - (5) Fax to other _____ Fax # _____

Please allow 1 to 2 weeks for completion.

If any questions, I can be reached at Phone # _____.

I am aware that there is a \$50.00 charge for each form requested to be completed and due at time of completion of form. I will be responsible for making the payment when I receive the form(s).

Authorized Signature Date

I am enclosing my credit card information so that I may have my credit card charged at the time of completion.

Credit Card # _____ MC/V/ Amex/Discover
Exp Date: _____ 3 digit sec code _____
Name on Card: _____ Billing zip code _____

Authorized Signature Date