

# NEWTON MEDICAL GROUP

ExamWorks IME Services

## Appointment Request

**To: Scheduling**                      **F: 510.463.0194**                      **P: 510.208.4700**                      **Date:** \_\_\_\_\_

**From:** \_\_\_\_\_ **Company:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Email:** \_\_\_\_\_

NMG Physician/Specialty: \_\_\_\_\_ NMG Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female  Gender Fluid

Patient Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Claimant's Attorney: \_\_\_\_\_ Claimant's Attorney: \_\_\_\_\_

Firm Name: \_\_\_\_\_ Firm Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Insurance: \_\_\_\_\_

Claims Examiner: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Type of appointment requested (check one):

AME  Defense  Applicant  AOE/COE

Re-Eval  Panel QME #: \_\_\_\_\_

Other (please specify): \_\_\_\_\_

Interpreter needed?:  No  Yes

Yes, language: \_\_\_\_\_

INJURY #1	INJURY #2
Date of injury: _____	Date of injury: _____
Body parts injured (description): _____	Body parts injured (description): _____
Claim #: _____	Claim #: _____
WCAB/EIMS #: _____	WCAB/EIMS #: _____

<b>Doctor:</b> _____	<b>Location:</b> _____
<b>Date:</b> _____	<b>Time:</b> _____
<b>Scheduled by:</b> _____	510-208-4700 ext. _____

*To avoid a late cancellation, late reschedule or no show fee, any change or cancellation must be received five business days prior to the scheduled appointment, excluding the date of the appointment. The day following the call to cancel or reschedule is counted as the first day.*