Central Jersey Orthopaedic Specialists, P.A.

WORK ACCIDENT

PATIENT NAME_____ DATE OF EXAMINATION____/____/____
LAST NAME, FIRST NAME

The following information is needed to help the doctor learn how you were injured, what treatment you've had, and other information needed for insurance claims. It will shorten examination time. Please answer the questions as best you can. If a question is not clear, do not guess; just place a question mark next to it and the doctor will ask what is needed. Read all choices before answering. Please do not squeeze writing; if you need more room, place an arrow → at the end of the line and continue on the other side. Thank you.

DATE OF ACCIDENT_____ **WHERE** IT OCCURRED (CITY,STATE)_____
(If you have been injured in more than one accident, please complete a separate form for each one.)

DATE INJURY REPORTED: _____ **PERSON** TO WHOM REPORTED:_____

YOUR CURRENT **JOB**:_____ □ FULL TIME □ PART TIME

CURRENT **EMPLOYER:**_____

ADDRESS OF EMPLOYER:_____

YOUR JOB AT TIME OF ACCIDENT (if different):_____ □ FULL TIME □ PART TIME

EMPLOYER AT TIME OF ACCIDENT (if different):_____

ADDRESS_____

PLEASE DESCRIBE HOW YOU WERE INJURED:_____

_____

_____

DATE OF FIRST VISIT TO DOCTOR/HOSPITAL/EMERGENCY ROOM,ETC. (MONTH/DAY/YEAR)____/____/____

NAME OF HOSPITAL(S) OR EMERGENCY FACILITY(IES) YOU WENT TO_____

_____

NAMES OF DOCTORS WHO TREATED YOU FOR THIS ACCIDENT_____

_____

WHERE HAVE YOU HAD X-RAYS, SCANS, ETC?_____

_____

HOW LONG UNABLE TO WORK IMMEDIATELY AFTER ACCIDENT:_____

EVER INJURED IN OTHER WORK ACCIDENT(S)? □ YES □ NO IF YES, WHEN?_____

EVER INJURED IN OTHER KINDS OF ACCIDENT(S)? □ YES □ NO IF YES, WHEN?_____
(e.g. slips and falls, motor vechicle accidents)