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:____ □ FULL TIME □ PART TIME

EMPLOYER AT TIME OF ACCIDENT: ____

ADDRESS, CITY, STATE: ____

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 DOCTOR(S) 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?_____________________________
(slip&falls, motor vehicle accidents, etc.)