ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

WORKERS' COMPENSATION

NEW PATIENT

NAME	DATE OF BIRTH

IF THIS INJURY IS RELATED TO A WORK-RELATED ACCIDENT, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

DATE OF INJURY/ACCIDENT

WHICH PART(S) OF YOUR BODY WAS INJURED? LEFT RIGHT	PRIOR TO THIS ACCIDENT, DID YOU HAVE A PROBLEM/PAIN IN THE AFFECTED AREA? YES NO
DID YOU SUSTAIN OTHER INJURIES DUE TO THIS ACCIDENT? YES NO	IF "YES", GIVE DETAILS (EX: LEFT HAND LACERATION)

DID YOU HAVE IMMEDIATE PAIN OF THE AFFECTED AREA AT THE TIME OF THE ACCIDENT OR A FEW DAYS LATER?
IMMEDIATE DAYS LATER (INDICATE NUMBER):

WHERE DID INJURY OCCUR? (LOCATION)	JOB TITLE ON DATE OF INJURY

HOW DID INJURY OCCUR?

DID YOU GO TO THE EMERGENCY ROOM? YES NO	IF "YES", WHERE?	DATE
DID YOU HAVE X-RAYS OR AN MRI? YES NO	IF "YES", WHERE?	DATE

WHAT WERE YOUR USUAL WORK ACTIVITIES ON THE DATE OF THE INJURY/ONSET?

EMPLOYER'S NAME WHEN INJURY OCCURRED

EMPLOYER'S ADDRESS AND PHONE # WHEN INJURY OCCURRED

HAVE YOU BEEN TREATED BY ANOTHER HEALTH CARE PROVIDER FOR THIS INJURY? YES NO	IF "YES", GIVE DETAILS

ARE YOU CURRENTLY WORKING? YES NO	IF "YES", DUTIES ARE REGULAR MODIFIED	IF "MODIFIED", GIVE DETAILS

IF YOU ARE NOT WORKING, WHAT IS THE DATE YOU FIRST MISSED WORK DUE TO THIS INJURY?

WAS THIS ACCIDENT THE RESULT OF A THIRD PARTY? (THIRD PARTY IS SOMEONE OTHER THAN YOU, OR YOUR OWN PERSONAL MEDICAL INSURANCE THAT IS LIABLE FOR COSTS ASSOCIATED WITH YOUR INJURY/ACCIDENT). YES NO

ARE YOU BEING COUNSELED BY A LAWYER FOR THIS INJURY?? YES NO	NAME OF ATTORNEY

SIGNATURE (PERSON COMPLETING FORM)	DATE COMPLETED

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