ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

WORKER'S 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