Work Injury Questionnaire

Patient_______________________________________ Date______________ Accident Date_____________

Accident Time_____________ Location____

Describe Accident____

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Employer____ Phone______________________________

Contact Person_______________________________________ Report Made? **Yes** **No**

Insurance Co.____ Claim #:_____________________________

Are you currently working? **Yes** **No** Time lost from work___________________to_____________________

Other doctors seen for this accident____

Attorney Involved_____________________________________ Phone______________________________

Address____

Additional Notes____

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Doctor Notes____

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Patient/Guardian Signature