Fullerton Foot and Ankle Specialists

DALE M. ROSENBLUM, DPM ERIC B. NAASZ, DPM

Workers Compensation Form

Last Name _____First Name_____Phone (____)_____

Address _____City _____

State _____Zip _____

Age _____ DOB ____/____/_____ Sex _____ Social Security # ____/____/____

Name of Compensation Carrier _____

Phone # (____) _____ Ext _____

Adjuster Name _____ Claim # _____
Fax (____) _____

Address of Carrier _____ City _____

State _____ Zip _____

Employer's Name _____

Phone (____) _____

Employer's Address _____ City _____

State _____ Zip _____

1 Type of Business _____

Your Occupation _____

2 Date Injured ____/____/_____ Hour ____ AM/PM Last Date Worked ____/_____/_____

Are you off work? ☐Yes ☐No

3 Accident reported to employer? ☐ Yes ☐ No

Name of person accident reported to _____

704 N. HARBOR BLVD
FULLERTON, CA 92832

Dr. Rosenblum: 714-525-8282
Dr. Naasz: 714-525-0225
Fax: 714-525-0141
FullertonFootandAnkle.com

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4 Injured at _____ City _____

State _____ Zip _____

5 Length of time worked there prior to accident _____
6 Type of work being done at time of injury
_____

7 In your own words, please describe the accident
_____

_____

_____

_____

8 Have you been treated by another doctor for this accident? ☐Yes ☐ No

If yes, please list doctor's name and address

_____

_____

What type of treatment did you receive?

_____

How long were you treated by this doctor?

_____

9 Are you: ☐Improved ☐Unchanged ☐Getting Worse

10 What types of medicine are you taking?
_____

Do these medicines help? ☐ Yes ☐ No ☐ Don't know

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11 Have you had physical therapy? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐Every other day ☐ Several times a week ☐Weekly ☐Every other week

☐Monthly Other _____

Does the physical therapy help? ☐ Yes ☐ No ☐ Don't know

12 Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

☐ Yes ☐ No ☐ Don't know

If yes, describe

_____

_____

_____

13. Were these similar complaints the result of a previous accident? ☐ Yes ☐ No
Please provide details of accidents

_____

_____

_____

14. Have you had any other serious accidents which required medical care? ☐Yes ☐No
Please describe

_____

_____

_____

15. Have you had any surgeries? ☐ Yes ☐No - If yes, list types of surgery and date below

_____

_____

_____

16. Have you had any nervous or mental illnesses? ☐ Yes ☐No

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Have you had psychiatric care? ☐ Yes ☐ No

17. Have you received a medical discharge from the Armed Forces? ☐ Yes ☐ No

18. Have you returned to work since these accidents? ☐Yes ☐ No

If you have returned to work since your accident, please fill out the information below:

_____

_____

Date Employer Occupation Light Duty or Regular Duty Full Time or Part Time

_____

_____

_____

_____

_____

_____

_____

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