CLIENT INFORMATION REPORT – MEDICAL MALPRACTICE

(Confidential)

All questions **MUST** be answered to the best of your ability. If this form is not complete your appointment may be subject to being rescheduled.

Date: _________________________

Injured Party: Name: ____

Address: ____

____

Telephone Nos.: Home: (_ _____)_____________________________

Cell: (_______)__________________________May we text you? Y N

Work: (__________)_____________________________

E-mail: _____ ___________________________________

Social Security No.: ______________________________

Date of Birth: ___________________________________

Age: ____________________

Employer's Name: _______________________________

Address:____

____

Telephone No.: (_________)________________________

Due to Section 111 Mandatory Medicare/Medicaid Reporting Requirements:

Are you a Medicaid recipient? YES NO

Are you a Medicare recipient (or will be within the next 30 months)? YES NO

If so, please provide your Medicare/Medicaid number: ___________________________________

Please list an emergency contact:

Name:___________________________________Relationship_______________

Address ____

Phone No.: (__________)__________________________

If Minor: Father's Name: ____

Address: ____

____

Telephone: (___________)____

Mother's Name: ____

Address: ______ ____ _________

____

Telephone No.: (__________) ___________________________________

Custody with: Father ☐ Mother ☐

Other: _____ ____

How were you referred to our office?

Turner & Sackett Website Internet Injury Helpline ☐

If by phone book, which one? Yellowbook ☐ Superpages ☐

Attorney ☐ Name:______ _____________________________________

Family Member/Friend ☐ Name:________________________________

Other: _____ ____

Clients frequently have a great deal of valuable information concerning how and why their accident occurred and who was at fault. Good lawyers should be aware of this and listen to their clients. Please help me help you by answering all of the following questions in as much detail as you can. Any problem important enough to see a lawyer is important enough to complete this form.

Write clearly, and only on the printed side of these pages. If more writing space is needed, attach other paper, identify each answer by question number, and write on one side of the page only.

ATTORNEY'S USE ONLY:____

Statute of Limitations: ____

____

1. **Injury:** Date of Injury or Dates of Treatment when Injury/Damage Occurred ________________

____

Time of Day _________________ AM PM Day of the Week ___________________

Location____

____

2. What treated for: ____

a. Names of doctor (treating medical personnel and addresses)________________________

____

____

____

b. Dates seen (for each) ______________________________________

____

____

c. Lab test, x-rays, other diagnostics studies undertaken and dates thereof______________

____

____

____

3. Hospitalizations (for each, list: date admitted, date discharged, surgery date(s), and consultants seen)

a. ____

____

____

b. ____

____

____

c. ____

____

____

4. Medical personnel who are believed to have caused or contributed to your injury:

a. Name: ____ ____

Address:_____ ____

____

Field of medical specialty:____ ____

Name and address of practice or employer (if applicable and if known)_____ ____________________

____

____

b. Name: ____

Address: ____ ____

____

Field of medical specialty: ____

Name and address of practice or employer (if applicable and if known) ____ ____________________

____

c. Name: ____ ____

Address: ____ ____

____

Field of medical specialty: ____

Name and address of practice or employer (if applicable and if known) _________________________

____

5. Witnesses to treatment/injury (nurses, therapists, or assisting medical personnel, family members or friends with knowledge):

a. Name: _______ ____

Address: ____

____

Telephone: (__________) ______________________________

Knowledge of treatment/injury ____

____

b. Name: ____

Address: ____

____

Telephone: (___________) ______________________________

Knowledge of treatment/injury ____

____

c. Name: ____

Address: ____

____

Telephone: (__________) ____________________________

Knowledge of treatment/injury ____

____

d. Name: ____

Address: ____

____

Telephone: (__________) ____________________________

Knowledge of treatment/injury ____

____

6. General description of what happened to have caused your injury: ______________________________

____

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7. Describe the injury or condition caused by alleged medical negligence: __________________________

____

____

____

8. Incident reports: Was incident/injury reported? _________ **To whom?** ________________________

________________________________ **When?** ______________________________________

List every entity which might have investigated the incident, including hospital personnel, insurance company, etc. ______ ____

____

____

____

9. Were any photographs taken of the person injured or of anything related to the incident? ___________

If so, please describe what photographs were taken, by whom they were taken, and who has current possession of the photographs _____ ____

____

____

10. History: Single ☐ Married ☐

Spouse's name: ____

Prior marriages? __________________ Former spouse's name: _________________________

____

How ended: Divorce __________ Date: ______________________

Annulment _____ __ Date: ____ ___________________

Death ____________ Date: ____ ___________________

11. Children:

a. Name ____

Age ______ _____________ Claimed as dependent? _____________________________

Address ____

____

b. Name ____

Age ______ _____________ Claimed as dependent? _____________________________

Address ____

____

c. Name ____

Age ______ _____________ Claimed as dependent? _____________________________

Address ____

____

d. Name ____

Age ______ _____________ Claimed as dependent? _____________________________

Address ____

____

12. Other dependents:

a. Name____

Age ______ ______ Relationship ____ ____

Address ____

____

Telephone No. (___________) ____

b. Name____

Age ______ ______ Relationship ____ ____

Address ____

____

Telephone No. (___________) ____

c. Name____

Age ______ ______ Relationship ____ ____

Address ____

____

Telephone No. (___________) ____

13. Your educational background and vocational training:

____

____

14. Employment:

Position ____

Date employed _____ ____

Rate of pay ______ _________ Gross _________________ Net ____________________

Dates lost from work because of this incident/injury/condition: From ______ __To_______

Total amount of wages lost ____

15. Prior work record:

a. Name of employer ____

Address of employer _____ ____

____

Dates of employment
________________________ ____
_

Type of work ____

Wages ____

Reason for leaving ____

____

b. Name of employer ____

Address of employer _____ ____

____

Dates of employment ____

Type of work ____

Wages ____

Reason for leaving ____

____

c. Name of employer ____

Address of employer _____ ____

____

Dates of employment ____

Type of work ____

Wages ____

Reason for leaving ____

____

16. Describe further or subsequent medical treatment necessitated as a result of injury/condition which is alleged to have been caused by claimed medical negligence and list names, addresses, dates of treatment, and bills for all doctors or hospitals that provided such further medical treatment.

a. ____

____

b. ____

____

c. ____

d.

17. Any insurance or compensation benefits paid for this injury?

By whom?

For dates?

Dates

Amounts

18. Responsible medical practitioner's insurance (if known)

Name of company

Address

Name, address, telephone number and employer of adjusters or insurance representative handling file, if known:

Any reports to them? When (date)

19. List all accidents in the past ten (10) years causing injury to you

20. List all lawsuits in which you were a party

21. List all prior hospitalizations for the past ten (10) years

a. Hospital

Date

Reason

b. Hospital

Date ____

Reason ____

____

c. Hospital ____

Date ____

Reason ____

____

22. List all prior major illness in life _______________________________________

____

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FOR ATTORNEY'S USE ONLY:

Statute of Limitations: _____ ______________________ Docketed by: ____________________________________

Medical Authorizations Signed: ____________________

Additional Instructions: ____ ____

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