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: (_____)_____

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 Law Offices 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: _____

_____

_____

_____

_____

_____

_____

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 _____

_____

_____

_____

_____

FOR ATTORNEY'S USE ONLY:

Statute of Limitations: _____ Docketed by: _____

Medical Authorizations Signed: _____

Additional Instructions: _____

_____

_____

_____

_____