

*For Attorney Only: Statute of
Limitations _____*

TURNER & SACKETT LLC

Wrongful Death Intake Form

Please complete this intake form is as much detail as possible. It is very important that this information is as thorough and accurate as possible.

Information of Person Completing this Form:

Name: _____

Relationship to Decedent: _____

Address: _____

Home Phone Number: _____

Work Phone Number: _____ Okay to contact you at this number: Y / N

Cell Phone Number: _____

Email Address: _____ Ok to email? Y / N

Emergency Contact's Name and Phone Number: _____

How were you referred to our Office? _____

Proposed Personal Representative

Name: _____

Relationship to Decedent: _____

Address: _____

Phone Number: _____

Social Security Number: _____

Date of Birth: _____

Have you ever been convicted of a felony? If yes, please explain

Have you ever filed a petition for bankruptcy: If yes:

Chapter: _____ Date Filed: _____

Date Discharged: _____ County: _____

Proposed Co-Personal Representative

Name: _____

Relationship to Decedent: _____

Address: _____

Phone Number: _____

Social Security Number: _____

Date of Birth: _____

Have you ever been convicted of a felony? If yes, please explain:

Have you ever filed a petition for bankruptcy: If yes:

Chapter: _____ Date Filed: _____

Date Discharged: _____ County: _____

Decedent's Information

Name: _____

Address: _____ County: _____

Date of Birth: _____

Social Security Number: _____

Married: _____ Name of Spouse: _____

Date, Time and Location of Occurrence: _____

Weather Conditions at time of Occurrence: _____

Date of Death: _____

Auto Insurance Company (if applicable): _____

Auto Insurance Adjuster Information (if applicable):

Health Insurance Information: _____

Medicare/Medicaid? If yes, Card Number: _____

Medical History

*** PLEASE COMPLETE THE ATTACHED HEALTH CARE PROVIDER INFORMATION SHEET ***

Was Decedent Employed at time of Accident: Y / N – If yes, please complete:

Name and Address of Employer: _____

Rate of Pay: \$ _____

Any known lawsuits filed by Decedent: _____

Did Decedent have property in Illinois or any other state? If yes, please identify the property and the location:

Did Decedent have a will: _____

List below the name, birthdate, age, address, and phone number of the following living relatives of the Decedent:

Father: _____

Mother: _____

Spouse: _____

Children:

Brothers & Sisters

(List if none of the above are living)

Brothers' Names, Addresses and Phone Numbers:

Sisters' Names, Addresses and Phone Numbers:

Information about the Negligent/At-Fault Party

Name: _____

Address: _____

Phone Number: _____

Social Security Number: _____

Driver's License Number: _____

Description of Vehicle: _____

Insurance Information (if known): _____

Claim Number: _____

Adjuster's Name: _____ Phone Number: _____

Owner of Vehicle: _____

Owner's Address: _____

Facts of the Accident

Please give a brief description of what happened

Did police respond to the accident: _____ If yes, please list agency and case number:

If so, do you know the disposition of the case? _____

Was decedent transported by ambulance: _____ If yes, please list agency's name and phone number:

Please list any witness (es):

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Any photographs of the accident or accident's location? _____

Additional information or comments:

Health Care Provider Information Sheet

*** ATTENTION ***

It is the client's responsibility to keep TURNER & SACKETT updated throughout the pendency of the case of any and all medical treatment and related medical bills associated with his/her claim. Any unknown medical bill(s)/liens/subrogations or any medical bill(s)/liens/subrogations provided after the conclusion of the case WILL BE THE RESPONSIBILITY OF THE CLIENT.

For Office Use Only:

DOA: _____

Injured Party: _____

Group Health Insurance Carrier: _____

Policy Number: _____

Insured: _____

Primary Care Provider's Name, Address and Phone Number _____

Please complete the information listed below for all physicians, hospitals, chiropractors, dentists, and oral surgeons, or any other medical provider who has treated you due to this accident.

Name of Provider/Facility: _____

Treating Physician: _____

Complete Address: _____

Phone Number: _____

Dates Treated: _____

Description of Treatment: _____

Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____

Treating Physician: _____

Complete Address: _____

Phone Number: _____

Dates Treated: _____

Description of Treatment: _____

Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____