

CLAIM FOR WORKERS' COMPENSATION
FACT SHEET

FACTS REGARDING CLAIMANT

***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 _____

1. Name: _____

2. Street Address or P.O. Box: _____

City: _____ State: _____ Zip code: _____

3. Telephone Number: Home: () _____

Work: () _____

Cell: () _____ May we text you? Y N

E-mail address: _____

4. Date of birth: _____

5. Age: _____

6. Social Security Number: _____ - _____ - _____

7. Marital status: _____

8. Name of spouse: _____ Age: _____

9. Names and ages of minor children:

10. Occupation: _____

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: _____

11. How were you referred to our office?

Turner Law Offices Website Internet Injury Helpline

Phone book, which one? Yellowbook Superpages

Attorney Name _____ Family Member/Friend Name _____

Other _____

12. Name and complete address of present employer: _____

13. Are you right or left handed? _____

FACTS REGARDING ACCIDENT

14. Name and complete address of employer at time of accident: _____

15. Date of accident: _____

16. Time of accident: _____

17. Place of accident: _____

18. Description of the job you were performing at time of accident: _____

19. Description of the accident: _____

20. Names and addresses of witnesses to accident: _____

21. Name and address of your supervisor at time of accident: _____

22. Name, job title and address of the person to whom you reported the accident: _____

23. Date and time you reported the accident: _____
24. Was the accident reported orally, written or both? _____
25. At the time of the report, did you receive a copy of the Illinois Industrial Commission Workers' Compensation handbook? _____
26. Description of what you reported: _____

27. What were your gross weekly earnings at time of accident? _____
28. Were you required to work overtime? _____ how often? _____
29. Description of your injuries: _____

30. For what period of time were you off work? (Give dates): _____

31. When were you released to return to work? _____
32. If you were released to return to work, who released you? _____

33. What was your rate of compensation while you were off work? \$ _____
34. How long did you receive such compensation? _____
35. What was the name of the insurance company from which you received the compensation? _____

36. Have you received a prior settlement offer for this injury from the worker's compensation insurance company? Yes / No. If so, please provide the details of the offer, or if a written offer, please provide a copy of the offer.

MEDICAL HISTORY - (Please complete the attached Health Care Provider Information Sheet)

37. Are you still being treated? _____

38. If so, state the treatment being received: _____

39. Will you require future treatment? _____

40. If so, describe treatment requirement: _____

41. Describe present physical complaints: _____

42. Have you been injured before? _____

43. If so, state when you were injured, the nature of the injury, the treatment of said injury, and any problems you still have as a result of said injury: _____

44. Have you filed a claim(s) in the Illinois Workers' Compensation Commission prior to this time? If yes, please explain: _____

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: _____