MEDICAL MALPRACTICE INTAKE

DATE: ____________________ TIME: ____________ INTAKE BY: ____________________

SOURCE / REFERRED BY: ____

NAME: ____ D.O.B.:____________________

ADDRESS: ____ APT/FL: __________

CITY: ____________________________________ STATE: ________________ ZIP: ________

HOME TEL.: ______________________________ WORK TEL.: ________________________

CELL NO.: _______________________________ S.S.N.: ____________________________

EMAIL ADDRESS: ____

MARITAL STATUS:_______________ SPOUSE'S NAME: _____________________________

NO. OF DEPENDANTS: ________ NAMES & AGES: _________________________________

PUBLIC ASSISTANCE (describe): ____

WRONGFUL DEATH INFORMATION

DATE OF DEATH: ______________________________ AUTOPSY PERFORMED: YES NO

CAUSE OF DEATH: _____________________________ DEATH CERTIFICATE: YES NO

PLACE OF DEATH: ____

HISTORY / FACTS

DATE & DESCRIPTION OF INJURY / SURGERY OR OTHER PROCEDURE: ________________________

____

DOCTORS INVOLVED: ____

HOSPITAL / CLINIC: ____

X-RAYS: ____________________ DATE: _____________ WHERE: ______________________

FINDINGS: ____

MEDICATIONS PRESCRIBED: ____

NAME & TEL. NO. OF EYEWITNESSES, PERSONS WITH KNOWLEDGE, ETC.: ____________________

____

DETAILS: ____

____

____

____

OTHER DOCTORS VISITED

NAME: ______________________ SPECIALTY: ______________________

ADDRESS: ______________________

TEL. NO.: ______________________ DATES: ______________________

NAME: ______________________ SPECIALTY: ______________________

ADDRESS: ______________________

TEL. NO.: ______________________ DATES: ______________________

MEDICAL HISTORY

NAME OF PRIMARY PHYSICIAN: ______________________

ADDRESS: ______________________ TEL.: ______________________

PRIOR MEDICAL CONDITIONS: ______________________

____

PRIOR ACCIDENTS/INJURIES: ______________________

____

PRIOR HOSPITALIZATIONS (dates and reasons): ______________________

____

INSURANCE INFORMATION

NAME OF INS. CO. (Private, Medicaid, Medicare, etc.): ______________________

INSURED NAME: ______________________ RELATIONSHIP: ______________________

ID NO.: ______________________

EMPLOYMENT INFORMATION

EMPLOYER: ______________________

ADDRESS: ______________________ TEL.: ______________________

DATE HIRED: ______________________ WAGES: ______________________

OCCUPATION/DUTIES: ______________________ TIME LOST: ______________________

EMERGENCY CONTACT

NAME: ______________________ RELATIONSHIP: ______________________

ADDRESS: ______________________ TEL. NO.: ______________________

OTHER ATTORNEYS CONSULTED

NAME: ______________________ CITY: ______________________

REASON NOT RETAINED: ______________________