DAY, DAY & BROWN
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Potential Medical/ Dental Malpractice Intake Form

Name: _____

DOB: _____

Phone number: _____

Email: _____

Date you first suspected medical/dental malpractice: _____

Medical malpractice against (please put doctor, dentist, or facility): _____

Have you seen subsequent treaters after said negligence? _____

Referred by: _____

Facts: (please provide a <u>detailed summary, in chronological order,</u> of your case below)

Example: On (date), I went to visit (doctor or facility) because of (reason for visit). After my visit with (doctor or facility) I came home to feeling dizzier than before. I later fainted and was rushed to the emergency room. Then, I found out that (prior doctor or facility) failed to diagnose or identify my brain bleed - after being seen and informed by (subsequent doctor or facility).