Medical Malpractice Information Packet

Date of Initial Interview: _____

Date of the Incident: _____

SOL: _____

A. Information about Client

1. Your full Name: _____ ____ _____
   (First) (MI) (Last)
2. Birth date: _____ Soc. Sec. No.: _____
3. Age: _____ Sex: _____ Driver License No.: _____
4. Street Address: _____
   City: _____ State: ____ Zip: _____
5. Phone: (H) (____) _____ (W) (____) _____ (C) ( ) _____
6. Marital Status: _____ Spouse's Name: _____
7. Children's Names and Ages:

   _____

   _____

   _____
8. Nearest Relative / address / phone number:

   _____

   _____
9. Names of all relatives living with you at the time of the accident and all children over the age of 16 years living anywhere:

   _____

   _____

   _____

B. Client's Medical Insurance

1. Name of Company: _____
2. Insurance in Name of: _____
3. Policy No.: _____

C. Information About Defendant/Medical Provider

1. Name: _____
2. Street Address: _____
3. City: _____ State: _____ Zip: _____
4. Phone: (____) _____

D. Defendant's Insurance Coverage

1. Name of Company: _____
2. Insurance in Name of: _____
3. Policy No.: _____ Adjuster: _____
4. Phone number of adjuster: _____

E. Explain what happened the day of the incident. What was the reason for your visit with the doctor / hospital / urgent care / dentist?

_____
_____
_____
_____

F. What injuries did you receive from this alleged medical malpractice?

_____
_____
_____
_____

G. Have you had any testing, MRI, x-rays, etc.? If so, where were the tests given.

_____
_____
_____
_____

H. What medical providers have treated you since your initial visit with the Defendant/Medical Provider? Provide their name, address, telephone, and their diagnosis.

_____
_____

_____
_____

I. Did you miss anytime from work? If so, please provide your employer's name, address, and telephone number.

_____
_____
_____
_____

J. What prescriptions are you currently taken? Are they related to the injuries you received from this accident?

_____
_____
_____
_____

K. Have you had any prior accidents/medical malpractice law suits (e.g., automobile accidents, slip and falls, medical malpractice)? If so, did you receive any funds?

_____
_____
_____
_____

L. Do you have any prior medical conditions?

_____
_____
_____
_____

O. Is there anything you would like to add? If so, use the space below.