DATE: _____ REFERRED BY: _____

PRIOR ATTY NAME: _____ OJCC#: _____

PREFERRED METHOD OF COMMUNICATION: EMAIL TEXT U.S. MAIL

PERSONAL INFORMATION

NAME: _____

ADDRESS:_____

_____

HOME PHONE # _____ CELL PHONE #_____

WORK PHONE # _____ OTHER PHONE # # _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

HAVE YOU EVER USED A FAKE SSN? _____

EMERGENCY CONTACT NAME: _____

PHONE #: _____ RELATIONSHIP: _____

ADDRESS:_____

_____

EMAIL ADDRESS: _____

DEPENDENTS: YES _____ NO _____ IF YES, HOW MANY? _____

LANGUAGE

NATIVE LANGUAGE: _____

CAN YOU SPEAK ENGLISH: _____ CAN YOU READ ENGLISH: _____

DO YOU NEED AN INTERPRETER FOR EVENTS? _____

DO YOU NEED TRANSPORTATION TO MEDICAL APPOINTMENTS? _____

OTHER COVERAGE

DO YOU RECEIVE: MEDICARE? _____MEDICAID? _____ VA BENEFITS? _____

PRIVATE HI? _____ UNEMPLOYMENT? _____ SOCIAL SECURITY? _____

ACCIDENT/INJURIES:

DATE & TIME OF ACCIDENT: _____

PLACE/COUNTY OF ACCIDENT: _____

DESCRIPTION OF ACCIDENT: _____

_____

_____

DESCRIPTION OF INJURIES: _____

_____

_____

ANY WITNESSES: _____

DID YOU TAKE A DRUG TEST: _____ IF SO, WHEN? _____

WHEN WAS ACCIDENT REPORTED TO AND TO WHOM? _____
WAS NOTICE OF INJURY COMPLETED? _____ COPY? _____
ANY PRIOR ACCIDENTS/INJURIES? _____ WORK ACCIDENTS/INJURIES? _____
IF YES, DESCRIPTION AND DATES ACCIDENT/INJURIES:_____

_____

_____

_____

_____

WERE ANY THIRD PARTIES INVOLVED: _____
ANY OTHER PENDING LAWSUITS? _____

EMPLOYER INFORMATION

NAME: _____
ADDRESS:_____
PHONE # _____ POSITION/DUTIES: _____
HIRE DATE: _____ SUPERVISOR NAME/TITLE: _____
ARE YOU CURRENTLY EMPLOYED? _____ IF SO, WITH WHOM: _____
ARE YOU ABLE TO WORK? _____ ANY LOST WAGES FROM THIS ACCIDENT? _____
ARE YOU RECEIVING LOST WAGES FROM W/C? _____ AMOUNT: _____
WERE YOU TERMINATED? _____ IF YES, EXPLAIN CIRCUMSTANCES:_____

_____

WAGE INFORMATION

HOURLY RATE: _____ SALARY: _____ WEEKLY HOURS: _____
PAID IN CASH? _____ PAID BY CHECK/DIRECT DEPOSIT? _____
DID YOU WORK OVERTIME? _____ WERE YOU PAID OVERTIME? _____
DID A CO-WORKER HAVE A SIMILAR POSITION AS YOU? _____
DID YOU WORK A SECOND JOB AT THE TIME OF THE ACCIDENT? _____
IF SO, NAME: _____
ADDRESS: _____
PHONE # _____HOURLY RATE: _____ PAY STUBS? _____

WORKERS' COMPENSATION INSURANCE CARRIER

NAME: _____
ADDRESS**:**_____

_____

PHONE # _____ ADJUSTER: _____
CLAIM # _____ NCM? _____
ANY EXPENSES PAID BY CARRIER? _____ MILEAGE? _____
PRESCRIPTIONS? _____OTHER OUT OF POCKET EXPENSES? _____

_____

MEDICAL CARE

(1) NAME: _____

ADDRESS**:**_____

_____

PHONE # _____ SPECIALTY: _____

AUTHORIZED: _____

(2) NAME: _____

ADDRESS**:**_____

_____

PHONE # _____ SPECIALTY: _____

AUTHORIZED: _____

(3) NAME: _____

ADDRESS**:**_____

_____

PHONE # _____ SPECIALTY: _____

AUTHORIZED: _____

(4) NAME: _____

ADDRESS**:**_____

_____

PHONE # _____ SPECIALTY: _____

AUTHORIZED: _____

(5) NAME: _____

ADDRESS**:**_____

_____

PHONE # _____ SPECIALTY: _____

AUTHORIZED: _____

(6) NAME: _____

ADDRESS**:**_____

_____

PHONE # _____ SPECIALTY: _____

AUTHORIZED: _____

HAVE YOU REQUESTED AND RECEIVED A (1) TIME CHANGE IN DOCTOR:_____

_____

DATE OF MMI: _____ IR:_____ DOCTOR:_____

ISSUES

SETTLEMENT INTEREST? _____

COMENTS:_____