Case # _____ Paralegal / Attorney _____	Completed By: _____ English / Spanish / Bilingual Needs Contracts: YES / NO

MEDICAL MALPRACTICE CHECK SHEET

_____ **vs.** _____

DATE CASE RECEIVED: _____ **REFERRAL BY:** _____
DATE OF INCIDENT: _____ **TIME OF INCIDENT:** _____
LOCATION OF ACCIDENT: _____
_____

PLAINTIFF:
NAME: _____ D/Birth: _____
ADDRESS: _____ SS # : _____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE: (Home) _____ (Work) _____ (Cell) _____
E-MAIL ADDRESS: _____
YOUR NEAREST LIVING RELATIVE: _____
THEIR ADDRESS: _____ THEIR PHONE: _____

ALL SOCIAL MEDIA ACCOUNTS

FACEBOOK: _____ OTHER: _____

INFORMATION NEEDED REGARDING INCIDENT:

DEFENDANT / DOCTOR / FACILITY:

NAME: _____
_____
_____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

DEFENDANT'S INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS OF INS. CO. _____

CITY: _____ STATE: _____ ZIP: _____

POLICY NO: _____ CLAIM NO: _____

ADJUSTER: _____ PHONE NO: _____

DID THIS DOCTOR / FACILITY HAVE MEDICAL MALPRACTICE INSURANCE? Yes ❑ No ❑

FACTS OF INCIDENT: (Please give brief description of what happened)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WITNESSES OF INCIDENT: (Name, Address, Phone number)_

1. _____

2. _____

3. _____

OTHER INFORMATION:

HAVE ANY DOCTORS STATED THAT THE CONDITION / INJURY IS PERMANENT? Yes ❑ No ❑

IF SO, PLEASE PROVIDE THE DOCTORS NAME, ADDRESS AND PHONE NUMBER.

_____

_____

_____

PLAINTIFF'S INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS OF INS. CO. _____

CITY: _____ STATE: _____ ZIP: _____

POLICY NO: _____ CLAIM NO: _____

ADJUSTER: _____ PHONE NO: _____

GROUP HEALTH CARRIER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY NO: _____ PHONE NO: _____

DEDUCTIBLE: Yes ❑ No ❑ If yes, how much? $_____

YOUR INJURIES AS A RESULT OF THIS INCIDENT:

_____

_____

_____

_____

_____

HAVE YOU HAD PHOTOS TAKEN OF YOUR INJURIES? Yes ❑ No ❑

AMBULANCE: Yes ❑ No ❑

NAME OF AMBULANCE: _____

NAME OF HOSPITAL: _____

DATE (S) OF ADMISSION AND / OR E.R. VISITS:

_____

_____

YOUR DOCTORS **THEIR ADDRESSES / PHONE NUMBER**

_____

_____

_____

_____

HAVE YOU INCURRED OTHER EXPENSES AS A RESULT OF THIS INCIDENT I. E. MILEAGE, PRESCRIPTIONS, HOUSE CARE, LAWN CARE, ETC.? Yes ❑ No ❑

_____

_____

_____

DOCTOR REFERRED TO: _____

_____

_____

HISTORY:

SINGLE: ❑ MARRIED: ❑ DIVORCED: ❑ WIDOWED: ❑

SPOUSE'S NAME: _____

CHILDREN: NAME AGE

_____

_____

_____

_____

OTHER DEPENDANTS: _____

EDUCATIONAL BACKGROUND:

SCHOOLS ATTENDED GRADUATED CERTIFICATES/DEGREES EARNED

_____

_____

_____

EMPLOYMENT HISTORY: (List ALL employers for the present and past 20 years)

PRESENT EMPLOYER: _____

ADDRESS & PHONE: _____

POSITION HELD: _____ JOB DESCRIPTION:_____

DATE EMPLOYED: _____RATE OF PAY: _____

DATES MISSED FROM WORK: _____WAGES LOST (IF KNOWN): _____

PREVIOUS EMPLOYER: _____

ADDRESS & PHONE: _____

POSITION HELD: _____ HOW LONG: _____ RATE OF PAY: _____

SELF EMPLOYED Yes ❑ No ❑ OTHER INCOME: _____

CAN YOU PROVIDE YOUR LAST FIVE YEARS TAX RETURNS? Yes ❑ No ❑

RECREATIONAL ACTIVITIES: _____

_____

_____

AS A RESULT OF THIS ACCIDENT HOW HAVE YOUR ACTIVITIES BEEN LIMITED: _____

_____

_____

MISC. INFORMATION: _____

_____

_____

_____

_____

_____

_____

_____