MALPRACTICE – INITIAL INTERVIEW

Date of Interview: _____ Attorney: _____

Referred by: _____

CONTACT PERSON (if different than injured party):

Name: _____

Address: _____

_____

Home Phone #: (_____)_____ Work Phone #: (_____)_____

Relationship to Injured Party: _____

INJURED PARTY:

Name: _____

Address: _____

_____

Home Phone #: (_____)_____ Work Phone #: (_____)_____

Date of Birth: _____ SS#: _____

Marital Status:

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Children: _____

_____

Parents or Spouse: _____

_____

Parents/Spouse DOB: _____ SS#: _____

Alternative Contact: _____

Relative/friends in area) Address: _____

EMPLOYMENT INFORMATION – INJURED PARTY:

Current/Latest Employer: _____

Address: _____

_____

Position: _____ Salary: _____

Dates of Employment: _____

Previous Employers: _____

_____

_____

Please provide income tax returns for last five years.

MEDICAL INFORMATION – INJURED PARTY:

Description of injury sustained due to negligence: _____

_____

_____

_____

_____

_____

Date of occurrence of injury: _____

Date of discovery of injury: _____

Estimated Statute of Limitations expiration date: _____

Limitations due to injury: _____

_____

_____

_____

_____

_____

_____

Photographs needed of injury? Yes _____ No _____

Date of alleged medical negligence: _____

Description of alleged medical negligence: _____

_____

_____

_____

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_____

_____

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_____

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_____

Name of allegedly negligent person: _____

_____

Address: _____

_____

Witnesses to alleged negligence: _____

_____

_____

_____

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_____

Pre-existing Medical Conditions: _____

_____

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_____

Family Doctor at time of incident: _____

_____

_____

_____

_____

Family Doctor(s) prior to incident: _____

_____

_____

_____

Requesting billing information from all providers? Yes _____ No _____

PHYSICIANS / OUTPATIENT CLINICS / HOSPITALS

Prior treatment:

#1 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

#2 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

#3 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

(Use separate sheet for additional providers)

PHYSICIANS / OUTPATIENT CLINICS / HOSPITALS

Prior treatment:

#1 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

#2 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

#3 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

(Use separate sheet for additional providers)

PHYSICIANS / OUTPATIENT CLINICS / HOSPITALS

Prior treatment:

#1 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

#2 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

#3 – Name: _____

Specialty of doctor / type of clinic: _____

Address: _____

_____

Phone #: (_____) _____

Dates of visit or admission: _____

Obtain which records? _____

(Use separate sheet for additional providers)