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Date: ______________

MEDICAL MALPRACTICE

Full Name: ______________________________

Address: ______________________ City: ______________

State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________

Fax: ______________ Email Address: ______________

Work Phone: ______________

DOB: ______________ Age: ______________

SSN: ______________ DLN: ______________

Marital Status : ______________ Name of Spouse: ______________

What is the act of Malpractice that occurred? ______________________

Date of Malpractice: ______________

Who was the Doctor or Health Provider that committed the ______________

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Malpractice? ____________________

What permanent injury or damage did you sustain? ____________________

Have you spoken to a doctor about this Malpractice? ____________________

Have you spoken to another attorney about this case? ____________________

What Health Care Provider are you currently treating with? ____________________

Name of Primary Health Care Insurer: ____________________

Phone Number of Primary Health Care Insurer: ____________________

Are you eligible for Medicaid/ Medicare? ☐ Yes ☐ No

If yes, please provide your Medicaid/ Medicare number: ____________________

Have you provided copies of any bills for injuries sustained from the malpractice to your Health Insurance Carrier for payment? ☐Yes ☐ No

If yes, what health care provider's bills have you turned over to your health insurance carrier? ____________________

SOL: ____________________

How were you referred to our office:

☐ Google ☐ Bing ☐Facebook ☐AVVO ☐ FindLaw ☐ Newspaper ☐ Radio

☐ Friend/Family: ____________________ ☐ Lawyer: ____________________

☐ Other: ____________________

FOR ATTORNEY USE ONLY:

Fee: ☐ Hourly ☐ Flat

General: ______________________

Escrow: ______________________

Filing Fee: ______________________

County: ______________________

ATTORNEY NOTES: