Date _____ **Attorney** _____

PERSONAL INJURY/WORKERS' COMPENSATION INFORMATION SHEET

TYPE OF CASE: Personal Injury ___ Workers' Compensation ___ Wrongful Death ___

_____ _____ _____

First Name (of injured person) Middle Name Last Name

DOB: _____ **SSN:** _____ **Male** ____ **Female** ____

_____ _____

Current Address **Person Present for Injured/Parents (if minor)**

_____ _____ _____

City State Zip Code Relationship Address

Name of Spouse: _____

Home Phone ( ) _____ _____

City State Zip Code

Work Phone ( ) _____ **How did you hear about us:** _____

Cell Phone ( ) _____ **Email Address:** _____

Work Name & Address: _____

_____

Date of Accident: _____ **Location of Accident:** _____

Responsible Party: _____

Responsible Party's Address: _____

Responsible Party's Insurance Company: _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

Claims Adjuster: _____

If Workers' Compensation: Employer: _____

Address: _____ **Phone:** _____

_____

_____

Part(s) of Body Injured: _____

Healthcare Providers Visited in Connection with Injuries:

(1) _____ **(4)** _____

Address: **Address:**

_____ _____

_____ _____

(2) _____ **(5)** _____

Address: **Address:**

_____ _____

_____ _____

(3) _____ **(6)** _____

Address: **Address:**

_____ _____

_____ _____

Do you have health insurance? _____

If yes, name of health insurance provider: _____

Is your health insurance provided by your employer or your spouse's employer: _____

Are you a Medicare recipient? _____

If yes, please provide your Medicare no.: _____