WORKER'S COMP. CLIENT INTAKE FORM

FILE NUMBER: ____________________

Attorney's Involved:	Referred By:

PRIMARY PLAINTIFF

Name:_________________________________Spouse:________________________

Street Address/P.O. Box/Apt. No:____

City/State/Zip:____

Home Phone:______________Cell Phone: _____________Work Phone:____________

Social Security No:____________________________Birth Date:__________________

EMAIL: ____

Have you applied for or are You receiving Social Security Benefits? Yes _____ No _________

Have you Applied for or are You Covered Under Medicare? Yes __________ No ___________

EMPLOYMENT INFORMATION

*******PLACE WHERE WORK-COMP. INJURY ACTUALLY OCCURRED*******

Client's Current Employer:____

Street Address/P.O. Box:____

City/State/Zip:____

Position:____

Description of Duties:____

____

____

____

____

____

____

____

PRIOR EMPLOYMENT

Employer:____

Street Address/P.O. Box:________________________________

City/State/Zip:______________________________________

Position:____

INJURY INFORMATION

Date of Injury:______________________________________

List Injury/Injuries:___________________________________

____

Brief Description of How Injury Occurred:_____________________

____

____

WORKER'S COMPENSATION CARRIER

Company:____

Street Address/P.O. Box:________________________________

City/State/Zip:______________________________________

Insured:____

HEALTH INSURANCE CARRIER

Insurance Company:__________________________________

Street Address/P.O. Box:________________________________

City/State/Zip:______________________________________

HEALTH CARE PROVIDERS

Name of Treating Physician:_____________________________

Street Address:_____________________________________

City/State/Zip:______________________________________

Name of Treating Physician:____

Street Address:____

City/State/Zip:____

Name of Treating Physician:____

Street Address:____

City/State/Zip:____

Name of Treating Physician:____

Street Address:____

City/State/Zip:____

COMMENTS