SLIP AND FALL

Identifying Information

Name:_______________________________________ Date:____________________

Address:_____________________________ County where you reside:______________

Are you currently employed? Y N Average YEARLY income: $_____________

Phone number where we can leave a confidential message:____________________

Email Address:_________________________ Social Security No.:_____-_____-_______

Emergency Name and Phone Number Contact:__________________________________

How were you referred to our office:____

Date of Injury: ___________________

Other Person/ Company Involved in your injury: _________________________________

Address where your injury occurred: ____

County where injury occurred: _________________________

Police and Ambulance

Were the police involved? Y N Do you have a copy of the police report? Y N

Name of police department: ________________________

Were you taken to the hospital by ambulance? Y N

Description of Incident:____

____

____

Damages

What injuries did you immediately/ currently suffer?

____

____

Treating Doctors:

Identify all doctors who treated from the date of the injury to present.

Name of Facility Name of Doctor Contact Number Reason for Visit

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Your Insurance Information:

Medical Insurance: _______________________ ID: __________________________________

Name of Insurance: _______________________ Phone: _______________Fax: ______________

Name of Insurance: _________________________ ID: __________________________________

Do you have MedPay Y N Phone: _______________Fax: ______________

Amount: $____________