Office Use Only
Worker's Compensation Yes No
Medicare Yes No

NON AUTOMOBILE RELATED
PLEASE PRINT CLEARLY

NAME: _____ SEX (M / F)

SPOUSE/GUARDIAN : _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____@_____

PHONE# _____ DOB: _____ Social Security# _____

WORK# _____ CELL # _____

HOW DID YOU FIND US? REFERRED BY: _____

TV AD: _____ YELLOW PAGES AD: _____ OTHER (explain) _____

ACCIDENT INFORMATION

DATE OF ACCIDENT: _____ TIME: _____(AM/PM)_____

PLACE OF ACCIDENT: _____

ACCIDENT DESCRIPTION: _____

_____

_____

_____

WHERE IS YOUR PAIN? _____

_____

POLICE PRECINCT: _____ ACCIDENT #: _____

WITNESSES (names & addresses): _____

_____

PLEASE DESCRIBE THE CONDITION THAT CAUSED YOU TO FALL: _____

_____

WHO WERE YOU WITH AT THE TIME OF YOUR FALL? (Name and address): _____

_____

DID YOU OR ANYONE TAKE PHOTOS OF THE CONDITION? _____YES_____NO

WHEN DID YOU FIRST NOTICE THE CONDITION?_____

_____

PLEASE TELL US WHAT THE LIGHTING WAS LIKE WHERE YOU FELL: _____

WHAT KIND OF FOOT WEAR WERE YOU WEARING? _____

WERE YOU CARRYING ANYTHING ? IF SO, WHAT?_____

DID YOU NOTIFY ANYONE OF THE FALL? ____ YES___ NO : IF SO, WHOM? _____

WAS AN INCIDENT REPORT PREPARED? _____ YES _____ NO

IF YOU KNOW, DID YOU FALL ON:

	YES	NO
PRIVATE PROPERTY	_____	_____
COMMERCIAL PROPERTY	_____	_____
CITY PROPERTY	_____	_____
OTHER	_____	

IN YOUR OPINION, WHO IS RESPONSIBLE FOR THE AREA WHERE YOU FELL?

_____

DO YOU KNOW OF ANYONE ELSE WHO FELL IN THE SAME AREA BEFORE OR AFTER YOU?

_____YES _____ NO; IF SO, WHO? _____

If you were treated at a hospital were you an INPATIENT OR OUTPATIENT. *Please circle one.*

Date of admission _____

Name and address of hospital:_____

_____

Were you treated by a doctor(s) or other people furnishing health services? ___Yes ___ No
Name and address of such doctor(s) or person(s)

_____

_____

Amount of health bills to date _____Will you have more health treatment Yes/No_____

At the time of the accident, were you in the course of your employment? Yes or No

Did you lose time from work?_____ If so how much time?_____

Were you receiving unemployment benefits at the time of the accident?_____

What are your average weekly earnings?_____

If you lost time from work, date absence began_____
Have you returned to work? Yes/No_____ If so, give date _____

Number of days you work per week_____ Number of hours per day _____

List the name and address of your employer and other employers for one year prior to the accident date giving occupation and dates of employment:

_____

As a result of your injury, have you had any other expenses? (Yes or no) _____
If so explain_____
Due to this accident, have you received or are you eligible for payments under any of the following?

New York State Disability Yes____ No____
Workers' Compensation Yes____ No____

WHAT IS YOUR PRIVATE HEALTH INSURANCE COMPANY: _____

ARE YOU RECEIVING PUBLIC ASSISTANCE AND/OR MEDICAID BENEFITS? YES OR NO

ANY PRIOR ACCIDENTS? INJURIES? IF SO PLEASE BRIEFLY EXPLAIN)

_____

_____

THE ABOVE STATED INFORMATION IS ALL TRUE TO THE BEST OF MY KNOWLEDGE. (PLEASE SIGN AND DATE BELOW)

_____ _____
CLIENT DATE

Note to Clients:

Clients deserve to be kept informed and updated on the status of their cases. We will make a continued effort assure that you understand what is happening with your case.
Please let me know whether you prefer periodic written updates, telephone updates, e-mail updates or schedule office appointment updates. Please check your choice(s).

_____ WRITTEN UPDATES

_____ TELEPHONE UPDATES

_____ SCHEDULED IN-OFFICE APPOINTMENTS

_____ E-MAIL UPDATES (e-mail address _____@_____)

THANK YOU