

S.A.M. LAW OFFICE LLC

Susan A. Marks, Attorney

Melissa C. Djonlich, Paralegal

Email completed for to mel@samlaw.info or fax to 847-577-2223

SOL: _____

MEDICAL NEGLIGENCE FACT SHEET

Date Completed: _____

Background Information

Name: _____

Other names known by: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____

Mobile: _____

Email: _____

Date of birth: _____ Social Security #: _____

Driver's license number: _____

Marital status: _____

Spouse's name: _____

Employer: _____

Address: _____

Job Title: _____ How have you been employed there? _____

Name of Supervisor: _____ Telephone: _____

Your last date worked before illness or injury: _____

Rate of Pay: \$ _____ per _____

Date returned to work: _____

What was your total income for the most recent IRS filing: Year: 20__

Total Income: \$ _____

Did you miss work time or other benefits or income earning potential because of your Accident: Yes [] No [].

How much work time did you miss due to the accident: _____

List each and every claim or lawsuit in which you have been involved in any way. Include approximate year and parties involved, reasons and results.

Have you ever been arrested? _____

If yes, please provide the following information:

Date: _____ Charge: _____

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Have you ever been convicted of a crime? Yes No

If yes, please provide the following information:

Date: _____ Charge: _____

Date: _____ Charge: _____

Result (fine, penalty, supervision, etc.) _____

Have you ever been charged with a crime of fraud or dishonesty: Yes No

Have you ever been convicted of a crime of fraud or dishonesty: Yes No

Have you ever filed for bankruptcy: Yes No

Which was filed CH 7 or CH 13 (circle one)

Date of filing: _____ Date of Discharge: _____

Attorney Name: _____ Telephone: _____

Have you ever been represented by another attorney for this Accident: Yes No

Attorney Name: _____ Telephone: _____

Address: _____

Did the Attorney withdraw: Yes No

Give us any other information you feel we should have to represent you effectively in this case:

Your Injuries and Damages

Body parts affected: _____

Describe your injury: _____

Why do you think the injury occurred: _____

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Is injury permanent? Yes No

Did death or disability result? Yes No If yes, please describe: _____

List all **INJURIES** that you received as a result of this incident of injury:

List the names and addresses of each and every **DOCTOR/PHYSICIAN/ SURGEON** who was involved in the incident of injury:

List the names and addresses of every **HOSPITAL** involved with the incident of injury:

Treatment

List the names and addresses of every **HOSPITAL** who have treated you for your injury and since the incident occurred:

List the names and addresses of each and every **DOCTOR** who have treated you for your injury and since the incident occurred:

List the names and addresses of all **PHYSICAL THERAPISTS** who have treated you for your injuries.

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