SAM LAW OFFICE, llc

121 SOUTH WILKE ROAD, SUITE 201
ARLINGTON HEIGHTS, ILLINOIS 60005

TEL: 847.255.9925
FAX: 847.577.2223
www.samlaw.info

Email completed form to larry@samlaw.info or fax to 847-577-2223

SOL: ________

MEDICAL MALPRACTICE 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: 2010 and 2011 ______________
Total Income: $______________
Did you miss work time or other benefits or income earning potential because of the injury: Yes [ ] No [ ].
How much work time was missed due to the injury: ______________________

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:
____
____
____
____

Decedent Information

Name: _________________________________
Address: _________________________________
Date of Birth: _________________________________
SSN: _________________________________
Date of ocurrance: _________________________________
Date of death: _________________________________
Auto insurance company (If Applicable): _________________________________
Health insurance information (Private Health Insurer/HMO/Medicare/Medicaid):
____
Negligent driver (If Applicable): _________________________________
County where death occurred: _________________________________
Did decedent have a will? _________________________________
Did decedent have property in Illinois? If yes, identify property:
____

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List below the name, age, address and phone number of the following living relatives of the decedent.

Mother ______________________________
Father ______________________________
Children ______________________________
Spouse ______________________________
Brothers & Sisters ______________________________

Injuries and Damages

Why do you think the injury occurred: ______________________________
____
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List the names and addresses of each and every **DOCTOR/PHYSICIAN/ SURGEON** who was involved in the incident of injury:

____
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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 the decedent:

List the names and addresses of each and every **DOCTOR** who have treated the decedent's injury:

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List the names and addresses of all **PHYSICAL THERAPISTS** who have treated the decedent's injuries.

____
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____
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Describe every past injury, accident, including work-related accidents, in which the decedent has ever been involved. (Include date, time, location, type of accident, and injuries.)

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List all illnesses or injuries for which the decedent was being treated at the time of the accident.

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Other information we need to know regarding the case:

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