

Re: Name:
Our File No.:
Date of Incident:

GENERAL INFORMATION

Complete and return to:

William E. Hahn, P.A.
Attn.: _____
310 S. Fielding Ave.
Tampa, FL 33606-2225
(813)250-0660

The following information is needed from you in connection with your Personal Injury/Medical Malpractice case. Much of the information requested will not necessarily be divulged to the defendant's insurance company or attorneys, but is very important that your lawyers have it now.

The information must be accurate, complete and truthful. It is of extreme importance that we know about **ALL** previous accidents, injuries, claims or lawsuits and that we have your **COMPLETE** medical background, particularly as it pertains to injuries sustained from this accident or injury. Please use the back of the pages if necessary to complete your answers. Please contact our office if you have any questions or doubts as to what information to include.

SECTION I: PERSONAL & FAMILY HISTORY

1. Your Full Name:_____ DOB:_____ SSN#:_____

2. Spouse's Full Name:_____ DOB:_____ SSN#:_____

3. By what other names/nicknames have you been known?

4. By what other names/nicknames has your spouse been known?

5. Referred by:_____

6. Home address:_____

7. Home Telephone: _____ Work Telephone: _____
E-mail address: _____

8. Florida DL#: _____ Issued: _____

9. Where were you born? City: _____ State: _____

10. Have you ever used any other dates of birth or social security numbers? YES/NO

If so, please list each and when and why used:

11. Are you married at the present time? YES/NO

Date of Marriage: _____ Place of Marriage: _____

12. Are you living together now? YES/NO

13. Have you ever been divorced or legally separated? YES/NO

If so, from whom, when and where?

14. Next of kin/contact: List the name and address of your nearest relative, close friend that can be contacted in your absence.)

15. List names, ages and addresses of all those (including children) who are dependent on you for support, and your relationship to each.

<u>Name</u>	<u>Address</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15a. List names, ages and addresses of any children you have not dependent on you for support.

<u>Name</u>	<u>Address</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. List where you have resided during the past ten (10) years and the period of time at each address:

SECTION II: EDUCATION (Injured party)

1. List below what education you have had to include high school, college, business courses or classes, special training of any nature, professional training or such:

<u>Institution</u>	<u>Dates</u>	<u>Degree/Certificate Obtained</u>	<u>Subject</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SECTION III: EMPLOYMENT (Injured Party or if injured party is a minor then parent/guardian)
(AT TIME OF INCIDENT)**

Your past employment records are very important in determining your disability and/or loss of earning capacity from an occupational viewpoint.

1. Were you employed at the time of the incident? YES/NO

If so, state the name of the company, address and phone number:

2. List your job title, position and describe your work and/or duties:

3. List the name of your immediate supervisor: _____

4. What was your rate of pay? \$ _____ Hours worked weekly: _____

5. Any additional benefits, bonuses? _____

6. When did you start with this company? _____

7. Have you remained on the job since the accident? YES/NO

8. If unable to work from injury, please list dates missed:

9. If you lost wages or pay from injury, please list the total amount to date:
\$ _____

10. Any increases or decreases in pay since the injury/accident? YES/NO

If so, please explain:

**SECTION IV: EMPLOYMENT HISTORY (Injured Party or if injured party is a
minor then parent/guardian)
(PRE-INCIDENT)**

List your employment records for the past 15 years. Begin with your current employer and work backwards:

1. From: _____ To: _____ Rate of Pay: _____

Name: _____

Address of employer:

Job Title: _____

Reason Left: _____

2. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer: _____

Job Title: _____ Reason Left: _____

3. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer: _____

Job Title: _____ Reason Left: _____

4. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer: _____

Job Title: _____ Reason Left: _____

5. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer: _____

Job Title: _____ Reason Left: _____

6. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer: _____

Job Title: _____ Reason Left: _____

SECTION V: EMPLOYMENT (Injured Party or if injured party is a minor then parent/guardian)
(POST-ACCIDENT)

If you have changed jobs since the accident or injury, complete the following:

1. Name/Address of employer:

2. Date Started: _____ Job Title: _____

3. Work performed or nature of duties:

4. Rate of pay and method (salary, commission, hourly): _____

5. Number of hours usually worked per week: _____

SECTION VI: EMPLOYMENT HISTORY (Spouse)

List your current employer and your previous employer:

1. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer:

Job Title: _____ Reason Left: _____

2. From: _____ To: _____ Rate of Pay: _____
Name: _____
Address of employer:

Job Title: _____ Reason Left: _____

SECTION VII: MILITARY BACKGROUND

1. Have you ever been rejected for Military Service because of physical, mental or other reasons? YES/NO

If yes, please explain: _____

2. Have you had military service? YES/NO Branch of Service: _____

From: _____ To: _____

3. Service Number: _____ Type of Discharge: _____

4. If you sustained any Service connected injury or disability, describe below:

5. Percentage of Disability Rating: _____

6. Present condition: _____

7. Do you receive payments? YES/NO Amount: \$ _____

SECTION VIII: POLICE RECORD

The defense may conduct a background investigation in this state as well as elsewhere to determine whether or not you have any police and/or criminal records. No matter what the circumstances may have been, it is imperative that your Lawyer be advised as to any criminal record.

<u>Charge</u>	<u>City/State</u>	<u>Date</u>	<u>Result</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION IX: MEDICAL HISTORY (Injured Party)

List all doctors and health care providers you have seen for the past 15 years including hospitals and ambulance companies. Starting with the most recent provider.

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____ Telephone: _____	Reason for care:
Dates of care:	Treatment:

Name: _____ Address: _____ _____	Reason for care:
Telephone: _____	
Dates of care:	Treatment:

PLEASE USE REVERSE SIDE TO LIST ADDITIONAL PROVIDERS

The following sections and pages pertain to the details of the accident/incident and the injury including medical treatment and damages incurred. Though we will be conducting our own investigation, we need to know what you saw and experienced at the time of the accident/injury and since the accident/injury. Please take your time, and be thorough and as accurate as you can be.

SECTION X: ACCIDENT/INJURY

1. Date of Incident: _____ Time: _____ AM/PM

2. Location: _____ City: _____ County: _____

3. Were you taken to a hospital by ambulance? YES/NO

4. If so, please list the following:

Ambulance Company/Agency: _____

Transported from: _____ To which hospital: _____

Invoice received: _____

5. List below everything the other party did that you feel caused and/or contributed to the accident or incident:

SECTION XI: WITNESSES

1. List below the names and addresses of any witnesses to the accident or events in dispute and your relationship if any with them:

<u>Name</u>	<u>Address</u>	<u>Relationship</u>	<u>Telephone number</u>
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4. Do you know of any photographs or videos taken in regard to the accident/incident?
YES/NO

If yes, please provide name, address and telephone number (if known) as to who has custody or control of any photographs or videos.

5. Were you questioned by anyone regarding the accident/injury? YES/NO

If so, did you give a statement? YES/NO

If yes, to whom was the statement given?

6. Have you ever been questioned by an adjuster or investigator? YES/NO If yes, by whom and when? _____

7. Were you provided with a copy of the statement? YES/NO

8. Have you signed any papers in regard to this accident? YES/NO

9. Give the details as to when this meeting took place:

SECTION XII: MEDICAL DAMAGES/INJURIES

1. State all injuries known or believed to have been sustained as a result of the accident or incident:

2. Disability:

Length of time hospitalized: _____

Time confined at home: _____

Back to work (light duty): _____

Back to work (full time): _____

State present physical condition - scars, limitations, deformities, discomforts, etc.:

3. List activities eliminated or hampered as a result of your injury. Any usual activities or such that you have **NOT** been able to engage in or perform since the accident (such as yard work, theater, travel, movies, sports, dance, bowling or hobbies):

**SECTION XIII: "OUT OF POCKET" EXPENSES
OTHER OBLIGATIONS (If injured party is a minor then
parent/guardian)**

1. Nurses/Therapists:

Billed: _____

2. Medical appliances/drugs and medications:

Billed: _____

3. Domestic household/help:

Billed: _____

4. Transportation expenses:

Billed: _____

(SUBMIT ALL BILLS, RECEIPTS, PROOFS OF PAYMENT TO OUR OFFICE)

SECTION XIX: PRIOR CLAIMS, LAWSUITS, ACCIDENTS, INJURIES (If injured party is a minor then parent/guardian)

Failure to mention prior injury or property damage claims, suits, accidents and injuries can undermine a lawsuit. It is NOT that these have taken place but that your **LAWYER** is not informed of them. Again, we must have a thorough knowledge of your background and any such cases. List below any such claims, suits or such to include claims under Worker's Compensation, Railroad Sickness benefits, and the Longshoremen's and Harbor Worker's act.

1. Date:_____ Nature of Incident:_____ Type injury/damage:_____
Claim/suit filed:_____ Against whom:_____
Results of claim/suit:_____

2. Date:_____ Nature of Incident:_____ Type injury/damage:_____
Claim/suit filed:_____ Against whom:_____
Results of claim/suit:_____

3. Date:_____ Nature of Incident:_____ Type injury/damage:_____
Claim/suit filed:_____ Against whom:_____
Results of claim/suit:_____

SECTION XX: ACCIDENTS AND INJURIES
(SINCE THIS ACCIDENT/INCIDENT)

1. Since the accident, have you been involved in any other accidents or sustained any damages or injuries? Yes/No

2. If answer is yes, please describe below listing the date of incident, accident or illness as well as the location and description of the accident or injury:

SECTION XXI: INSURANCE & WORKER'S COMPENSATION (Injured Party or if injured party is a minor then parent/guardian)

1. Your Health Insurance:

Name of Insurance Company: _____

Address: _____

Policy/ID number data: _____

Group number: _____

Contact person: _____

2. Medicare/Medicaid/Other:

Address: _____

Contact person: _____

I.D. Number: _____

3. Worker's Compensation: Were you injured on the job or during the course and scope of your employment? Yes _____ No _____

Are you receiving payments at this time? Yes/No If so, explain:

Name and address of attorney handling the file:

4. Other Sources:

Are you receiving disability payments from any source other than Worker's Compensation at present? If so, please explain in detail:

5. Social Security disability:

Have you applied for Social Security disability? Yes____ No____

If so, what is the status?_____

Are you receiving payments? Yes____ No____

If so, explain:_____

6. Disability Insurance:

Do you have disability insurance? Yes____ No____

If so, who is the carrier (name, address and phone number):

Are you receiving payments? Yes____ No____

If so, explain:_____

Thank you for your assistance and patience in completing this form. As a reminder, we caution you against discussing this case with persons other than our staff and your lawyers.

**ANYONE CONTACTING YOU REGARDING THIS MATTER
SHOULD BE REFERRED TO OUR OFFICE.**

(Please sign)

(Date completed)