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**MEDICAL NEGLIGENCE QUESTIONNAIRE**

In order to effectively represent your legal interests, we need **honest**, **accurate**, and **complete** answers to the questions listed below. Please carefully respond to the best of your ability. The failure to do so may severely compromise your claim and/or result in this firm's immediate withdrawal.

**A. Client Identification**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State and Zip Code \_\_\_\_\_  
Telephone \_\_\_\_\_  
Date Of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Marital History \_\_\_\_\_

**B. Employment History**

Occupation \_\_\_\_\_  
Employer's Name, Address And Telephone Number \_\_\_\_\_  
\_\_\_\_\_  
Immediate Supervisor's Name \_\_\_\_\_  
Salary Or Hourly Rate \_\_\_\_\_  
Number Of Hours Worked Before And After Incident \_\_\_\_\_  
Total Amount Of Work Missed As A Result Of This Incident \_\_\_\_\_

**C. Your Health Insurance Coverage**

Name Of Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_  
Insurance Agent's Name, Address And Telephone Number \_\_\_\_\_  
\_\_\_\_\_

**D. Incident Facts:**

**E. Medical Providers**

List All Medical Providers you believe caused your injury:

1. Witnesses\* \_\_\_\_\_  
\*Give The Name, Address, And Telephone Number Of Each Medical Provider

2. Witnesses\* \_\_\_\_\_  
\*Give The Name, Address, And Telephone Number Of Each Medical Provider

3. Witnesses\* \_\_\_\_\_  
\*Give The Name, Address, And Telephone Number Of Each Medical Provider

**F. Injuries**

Describe Nature Of Injuries \_\_\_\_\_  
\_\_\_\_\_

Photographs? \_\_\_\_ Yes \_\_\_\_ No

Any Serious Pre-Existing Medical Problems? \_\_\_\_ Yes \_\_\_\_ No

Did Your Injury Aggravate Any Pre-Existing Medical Problems? \_\_\_\_ Yes \_\_\_\_ No

If So, Please Explain: \_\_\_\_\_  
\_\_\_\_\_



G. **Other Doctors and Medical Providers**

Please Provide The Names Of All Doctors and/or Facilities Who Treated You **Before** This Incident:

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Please Provide The Names Of All Doctors and/or Facilities Who Have Treated You **After** This Incident:

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Have You Ever Been in Any Other Accidents in Which You Suffered Injuries That Led To Any Medical Care, Consultation, Exams or Treatment?  Yes  No If Yes, Please Explain the Circumstances \_\_\_\_\_

Have You Ever Made a Claim Against Any Person or Organization for Injuries or Damages before this Incident?  Yes  No If Yes, Please Explain the Circumstances \_\_\_\_\_

Have You Ever Been a Party to a Lawsuit?  Yes  No If Yes, Please Explain the Circumstances \_\_\_\_\_

Have You Ever Been Arrested and/or Convicted of a Crime?  Yes  No  
If Yes, Please Explain: \_\_\_\_\_