WORKER'S COMPENSATION INTERVIEW FORM #19

CONRAD TROSCH & KEMMY, P.A.

CLIENT INFORMATION

Name: _____
(Full Name: first, middle, last)

Birthdate: ____/____/____ Social Security #: _____-____-_____

Maiden Name (If Applicable):_____

Address: _____
Street Number and Name

_____
City, County, State Zip Code

***If it is not appropriate to send mail to you here, please give us an alternate address**:

_____

Phone Numbers: Home _____Work_____

Other_____

Name and phone number of alternate contact (for emergency only):

_____ #_____

Whom may we thank for referring you to this law firm?_____

Place of employment: _____

Employment description: _____

Do you have health insurance?:Yes ____ No ____

Is your health insurance provided through your employer? Yes ____ No ____

Insurance Provider:_____

Policy Number:_____

Do you receive Medicare benefits? Yes ____ No ____

Medicare Number:_____

Date of Injury:____/____/____

Time and place of injury: _____

_____

Worker's Compensation Insurance Provider:_____

Policy Number:_____Claim Number: _____

Did you notify your employer o the injury? Yes ____ No ____

Was there an incident report filed? Yes ____ No ____

Did your doctor say you should not work because of this injury? Yes ____ No ____

For how long? _____

When did you return to work? ____/____/____

What were your medical expenses? _____

How much time were you absent from your job as a result of the injury?

_____

Please provide a brief description of what happened: _____

_____

_____

_____

Do you have any photographs related to the accident? Yes ____ No ____

What were your injuries? _____

_____

_____

_____

Do you have any dependents? _____

_____

Salary and benefits information:_____