WELCOME!

A PARTNERSHIP OF PROFESSIONAL ASSOCIATIONS

SOCIAL SECURITY INTAKE

DATE OF ACCIDENT: _____/_____/_____

PLEASE TELL US ABOUT YOURSELF

First Name:_____ Middle_____ Last_____

Address:_____

City:_____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Mobile Phone: (____) _____ - _____ Name of Mobile provider?_____

Social Security #_____ Date of Birth:_____/_____/_____

Marital Status: ❒ Single ❒ Married, Date:____/____/_____ Spouse's Name: _____

❒ Separated, Date:____/____/_____ ❒ Divorced, Date:____/____/_____ ❒ Widowed, Date: ____/____/_____

Children: ❒ Yes ❒ No If yes, how many? _____ Highest school grade completed: _____

Do you have a current driver's license, or identification card? ❒ Yes / ❒ No If so: State _____

Driver's License # _____

Email Address:_____

PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE

How did you hear about our office? (Please check all that apply)

❒ TV ❒ Internet ❒ Road Sign ❒ Relative ❒ Friend ❒ Former Client ❒ Phone Book ❒ Referral Service

❒ Other, please explain:_____

_____

(Turn Over for page 2)

PLEASE TELL US ABOUT YOUR ACCIDENT / INCIDENT

LIST THE DOCTORS WHO YOU HAVE SEEN IN THE ORDER YOU SAW THEM

Have you applied for Social Security Disability Benefits? ❒ Yes ❒ No

Date Applied: _____/_____/_____

Date Employer Notified: _____/_____/_____ Person Notified: _____

Did you receive a denial notice? ❒ Yes ❒ No

Date of Denial: _____/_____/_____County: _____ State: _____

Have you filed an appeal? ❒ Yes ❒ No

PLEASE TELL US ABOUT YOUR INJURIES

What prevents you from working? _____

_____

_____

_____

_____

PLEASE TELL US ABOUT THE HOSPITALS/CLINICS WHERE YOU WERE TREATED

Hospital/Clinic: _____ Date(s): ____/____/_____ to ____/____/_____

Hospital/Clinic: _____ Date(s): ____/____/_____ to ____/____/_____

Hospital/Clinic: _____ Date(s): ____/____/_____ to ____/____/_____

Hospital/Clinic: _____ Date(s): ____/____/_____ to ____/____/_____

Physician #1: _____ Dates Seen: ____/____/____ to ____/____/____

Injury: _____

Physician #2: _____ Dates Seen: ____/____/____ to ____/____/____

Injury: _____

Physician #3: _____ Dates Seen: ____/____/____ to ____/____/____

Injury: _____

Physician #4: _____ Dates Seen: ____/____/____ to ____/____/____

Injury: _____

Physician #5: _____ Dates Seen: ____/____/____ to ____/____/____

Injury: _____

HAS ANY DOCTOR GIVEN YOU A DISABILITY RATING?

Rating Physician: _____ MMI Date: ____/____/____ Rating: _____%

Rated Injury: _____

Rating Physician: _____ MMI Date: ____/____/____ Rating: _____%

Rated Injury: _____

WHO IS YOUR FAMILY PHYSICIAN?

Name: _____ Phone Number: (____) _____ - _____

Address: _____

City: _____ State: _____ Zip : _____

How long has he/she been your family physician? _____

INJURIES/ACCIDENTS YOU HAVE HAD BEFORE YOUR ACCIDENT?

Have you had ANY injuries prior to this accident that required medical attention? Please tell us:

Date ____/____/____ Types of injuries: _____ Legal action taken?_____

Date ____/____/____ Types of injuries: _____ Legal action taken?_____

Date ____/____/____ Types of injuries: _____ Legal action taken?_____

(Turn Over for page 4)

PLEASE TELL US ABOUT YOUR EMPLOYMENT AT THE TIME OF YOUR INJURY

EMPLOYER #1

Occupation: _____ Work Responsibilities: _____

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Benefits Coordinator: _____

Phone: (____) _____ - _____ Length of Employment: _____ Years _____ Months

Hours per Week: _____ Pay Rate: _____ Gross Pay Per Week: _____

Fringe Benefits: _____

EMPLOYER #2

Occupation: _____ Work Responsibilities: _____

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Benefits Coordinator: _____

Phone: (____) _____ - _____ Length of Employment: _____ Years _____ Months

Hours per Week: _____ Pay Rate: _____ Gross Pay Per Week: _____

Fringe Benefits: _____

PLEASE TELL US ABOUT YOUR **CURRENT** EMPLOYMENT **IF DIFFERENT** FROM ABOVE

Employer's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Benefits Coordinator: _____

Phone: (____) _____ - _____ Length of Employment: _____ Years _____ Months

Hours per Week: _____ Pay Rate: _____ Gross Pay Per Week: _____

PLEASE TELL US ABOUT THE STATUS OF YOUR CASE

Have you missed time from work? ❒ Yes ❒ No Was the accident work-related? ❒ Yes ❒ No

How much time have you missed from work: _____ Are you still off work? ❒ Yes ❒ No

Are you receiving any wage-loss benefits? ❒ Yes ❒ No If yes, what is the amount of your bi-weekly check: $_____

Do you have medical expenses unpaid? ❒ Yes ❒ No Do you have lost wages unpaid? ❒ Yes ❒ No

PLEASE TELL US ABOUT YOUR HEALTH INSURANCE

Do you have health insurance? ❒ Yes ❒ No If yes, which health insurance company: _____

Policy #: _____ Member I.D. #: _____ Other #: _____

Do you receive ❒ SOCIAL SECURITY DISABILITY ❒ MEDICARE ❒ SSI ❒ MEDICAID?

Has your HEALTH INSURANCE or MEDICARE / MEDICAID paid any of your bills? ❒ Yes ❒ No

Do you have Short or Long Term Disability insurance? ❒ Yes ❒ No

If yes, name of Disability Insurance Company: _____

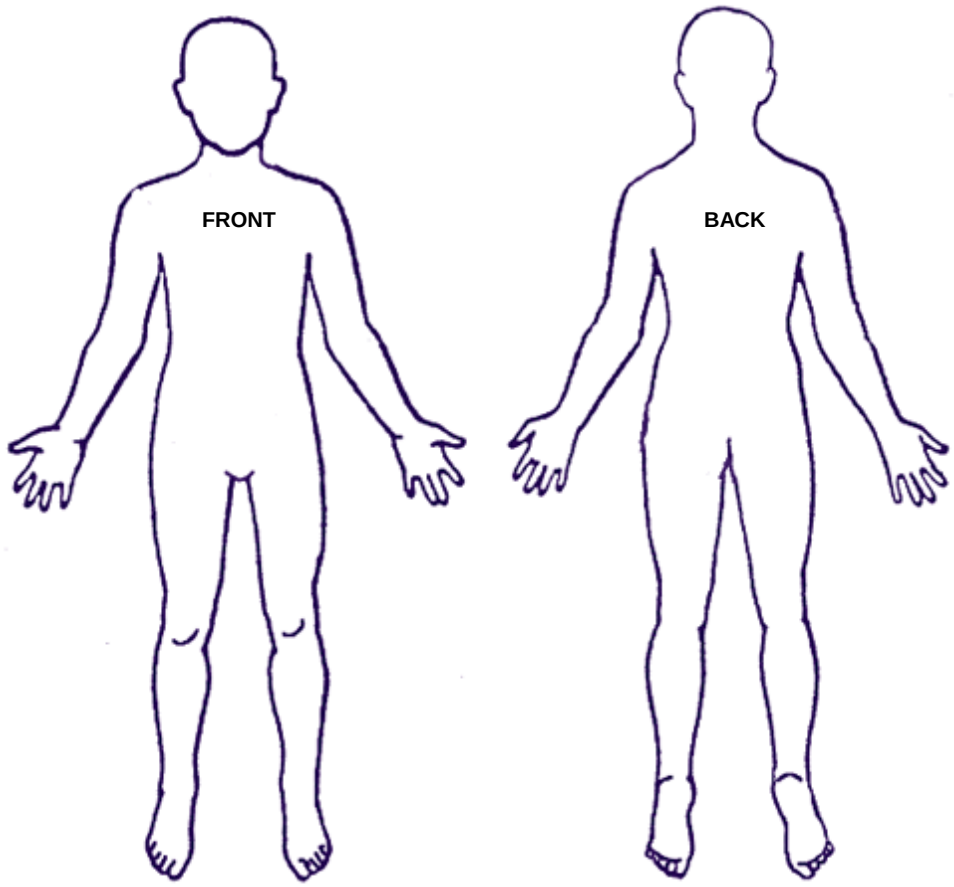
PLEASE TELL US ABOUT ANY DIFFICULTIES YOU ARE HAVING

IF YOU HAVE BEEN PREVIOUSLY REPRESENTED BY AN ATTORNEY FOR **THIS** ACCIDENT, PLEASE TELL US

Attorney Name:_____ Phone: (____) _____ - _____

Address:_____ City:_____ State: _____ Zip: _____

ON THE DIAGRAM, PLEASE CIRCLE OR PLACE AN X ON THE PART(S) OF YOUR BODY THAT WERE INJURED



FOR OFFICE USE ONLY:

Intake Date: _____/_____/_____ Statute of Limitations:_____/_____/_____

Notes: _____