ACCIDENT LAWYERS

JOHN FAGAN

INJURY - DISABILITY

Date of Injury:_____/_____/_____

Client: _____

IMPORTANT:

We must have the information in this survey to complete your claim!

Please complete this survey and return it to us within the next **10 days**.

PRE-ACCIDENT SURVEY #1

1. EMPLOYMENT HISTORY

1.1 Employment at the Time of Your Accident

Employer: _____

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

Job Title: _____ Date employment began: ____/____/____

Salary Rate of Pay: $_____ Per: _____ How many hours per week: _____

Hourly: $_____ Per: _____ How many hours per week: _____

Benefits: _____

Amount you earned in the last full year before your injury: $_____ Did you receive a W-2: ☐ Yes ☐ No

Have you filed Income Tax Returns for the last 5 years: ☐ Yes ☐ No Do you have copies: ☐ Yes ☐ No

1.2 Five Year Employment History

Most recent employer BEFORE your current one: _____

Employer: _____

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

Dates of Employment: From: ____/____/____ To: ____/____/____

Nature of Work: _____

Salary Rate of Pay: $_____ Per: _____ How many hours per week: _____

Hourly: $_____ Per: _____ How many hours per week: _____

Benefits: _____

Next most recent employer: _____

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

Dates of Employment: From: ____/____/____ To: ____/____/____

Nature of Work: _____

Salary Rate of Pay: $_____ Per: _____ How many hours per week: _____

Hourly: $_____ Per: _____ How many hours per week: _____

Benefits: _____

1.3 Spouse's Employment

Is your spouse presently employed: ☐ Yes ☐ No If yes, please furnish the following:

Name of employer: _____

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

Present job title: _____ Date hired: _____/_____/_____

Salary Rate of Pay: $_____ Per: _____ How many hours per week: _____

Hourly: $_____ Per: _____ How many hours per week: _____

Benefits: _____

2. HEALTH AND HOSPITALIZATION HISTORY

2.1 Past Hospitalizations Before Your Accident

Were you EVER AT ANYTIME received treatment at a hospital BEFORE this accident for any reason: ☐ Yes ☐ No
If yes, please complete the following:

Most recent hospital treatment BEFORE the accident: _____

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

Reason for Hospital treatment: _____

Length of Hospital treatment: From: _____/_____/_____ To: _____/_____/_____

Next hospital treatment BEFORE the accident: _____

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

Reason for Hospital treatment: _____

Length of Hospital treatment: From: _____/_____/_____ To: _____/_____/_____

Next hospital treatment BEFORE the accident: _____

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

Reason for Hospital treatment: _____

Length of Hospital treatment: From: _____/_____/_____ To: _____/_____/_____

2.2 Past Illnesses

BEFORE this accident, did you have had ANY long-lasting, chronic or serious illnesses for which you sought medical treatment? ☐ Yes ☐ No If yes, please complete the following:

Doctor: _____City:_____State:_____

Date: ____/____/_____Nature of Illness:_____

Doctor: _____City:_____State:_____

Date: ____/____/_____Nature of Illness:_____

Doctor: _____City:_____State:_____

Date: ____/____/_____Nature of Illness:_____

2.3 Accidents, Broken Bones or Injuries Before This Accident

BEFORE this accident did you have any injuries or medical conditions of any kind which required medical attention? ☐ Yes ☐ No If yes, please furnish the following information:

Doctor: _____City:_____State:_____

Date: ____/____/_____Nature of Accident:_____

Injury: _____

Doctor: _____City:_____State:_____

Date: ____/____/_____Nature of Accident:_____

Injury: _____

Doctor: _____City:_____State:_____

Date: ____/____/_____Nature of Accident:_____

Injury: _____

2.4 Past Medical/Dental Information

In the **FIVE** YEARS BEFORE YOUR ACCIDENT, who has been your regular family doctor and dentist that you have consulted when you needed medical attention? If more than one doctor, dentist, osteopath, chiropractor, or other physician has been used by you, please indicate below.

Primary Care Doctor:_____ Dates Seen: _____ through _____

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

Reason(s) for treatment: _____

Dentist:_____ Dates Seen: _____ through _____

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

Reason(s) for treatment: _____

Other Dr. or Health Care Provider:_____ Dates Seen: _____ through _____

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

Reason(s) for treatment: _____

Did you use any drugs or medications regularly (more than one refill) BEFORE your accident: ☐ Yes ☐ No

If yes, please name each drug or medication and its purpose:

Drug:_____ Purpose:_____

Drug:_____ Purpose:_____

Drug:_____ Purpose:_____

Drug:_____ Purpose:_____

Have you EVER had any auto, life or health insurance declined or canceled: ☐ Yes / ☐ No If yes, please indicate which and, give the date and reason:

☐ Auto: Date: _____/_____/_____ Reason:_____

☐ Life: Date: _____/_____/_____ Reason:_____

☐ Health: Date: _____/_____/_____ Reason:_____

3. INSURANCE INFORMATION

3.1 Medical Insurance

Do you have any medical insurance policies, including any medical insurance through your employment, or a private medical policy: ☐ Yes ☐ No If so, please furnish the following information:

Name of Insurance Company:_____

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

Insurance Agent, if any:_____ Policy Number:_____

Who pays for this coverage:_____

Have you made any claim for payment of your accident-related medical bills from:

Your medical insurance: ☐ Yes ☐ No

Medicaid/Medicare: ☐ Yes ☐ No

Other insurance company: ☐ Yes ☐ No

Other sources: ☐ Yes ☐ No

If any of your accident related medical bills been paid by a health insurance company, Medicaid, Medicare or any person other than yourself, please furnish the following information:

Name of entity paying bills:_____

Name of entity paying bills:_____

Name of entity paying bills:_____

Do you have any insurance of any kind which would provide disability payments: ☐ Yes ☐ No If yes, please furnish the following information:

Name of Insurance Company:_____

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

Insurance Agent: _____Phone No: _____