

CLIENT INFORMATION SHEET

The information you give us on this form is very important. It will help us investigate your case and determine how to best proceed with your case. If you don't have all the information we ask for in this form, please let us know so we can help you get it. All of your answers will be kept strictly confidential.

Today's date: _____

How were you referred to **The Law Offices of Dianne L. Sawaya, LLC?**

PERSONAL INFORMATION

Name: _____

Date of birth: _____ Social Security No. _____

Address: _____ Apt.: _____

City: _____ State: _____ ZIP : _____

Telephone no.: (Home) _____ (Work) _____

(Cell) _____ E-mail: _____

Height: _____ Weight: _____ Are you: Right-handed _____ Left-handed: _____

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's name: _____ Spouse's phone no.: _____

Dependents and ages: _____

Your driver's license: No. _____ Exp. date: _____

******IMPORTANT INFORMATION******

Please list the name of a relative or friend who does not live with you:
(for contact in an emergency and we can't reach you)

Name: _____ Phone no.: _____

Please list the names of the medical providers (doctors, nurses etc.) involved in this incident, and the medical facility or facilities where this incident took place:

Doctors: _____

Nurses: _____

Other providers: _____

Hospital/surgery center: _____

Other: _____

Please list *any* surgeries you have had before this incident, including surgeries for the same condition:

Date	Surgery	Doctor	Hospital
_____	_____	_____	_____
_____	_____	_____	_____

OTHER IMPORTANT INFORMATION

Have you make any statements to anyone about this incident? Yes ___ No ___

To whom: _____

When did you make these statements? _____

What did you say? _____

Has anyone make any statements to you about this incident? Yes ___ No ___

Who made the statements? _____

When did they make these statements? _____

What did they say? _____

Do you have health insurance? Yes ___ No ___

Name of plan: _____

Insurer contact: _____ Phone no.: _____

Group/policy no.: _____ Member no.: _____

Does Medicare or Medicaid pay any of your medical bills? Yes ___ No ___

If yes, what is your Medicare/Medicaid no.: _____

INFORMATION ABOUT YOUR WORK

Were you on the job at the time of the accident? Yes ___ No ___

Has this incident affected your ability to do your job? Yes ___ No ___

If yes, please complete the following information:

Employer's name: _____

Employer's address: _____

City: _____ State: _____ ZIP : _____

What is your occupation? _____

Income at the time of the accident: \$ _____ per _____

Any other income (commissions, bonuses, second job etc.): \$ _____

Income now: \$ _____ per _____

As a result of this accident, have you missed any time from work? Yes ___ No ___

Are you working now? Yes ___ No ___

Are you receiving worker's compensation insurance? Yes ___ No ___

Are you receiving disability insurance? Yes ___ No ___

For how many days so far: _____

Name of the doctor who told you not to work: _____

Doctor's address: _____

City: _____ State: _____ ZIP : _____

Is there anything else you can think of that we should know?

*Thank you for taking your time to fill out this form. It provides us with valuable information that we need to properly take care of your case. Please be assured that **we will keep this information strictly confidential** and will not release it to anyone outside The Law Offices of Dianne L. Sawaya, unless you tell us to or give us permission to as part of your case, or as may be required by law.*