LAW OFFICES OF KEVIN M. SMITH, P.A.
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INTAKE FORM FOR MEDICAL MALPRACTICE REPRESENTATION

Name:_____
last first m.i.

Address:_____
street city state zip

Telephone:_____
home/cell work

SSN:_____ DOB:_____

1. Date of surgery/discovery of medical treatment-related injury (for statute of limitations purposes):_____

2. Names of health care providers, treatment facilities, pharmacies, etc. (for conflict of interest purposes):_____
_____
_____

3. Are you still receiving medical treatment for the resulting injury?_____

4. Have you signed any waivers or endorsed any check from an insurance company relating to this incident?_____ If yes, how much have you received?_____

5. Have you ever filed a claim against an insurance company for personal injury-related medical expenses in the past?_____ If so, what insurance company(s)?_____
_____

6. Have you retained an attorney for this case yet?_____ If so, provide his or her name, address and telephone number:_____
name address telephone

7. If yes to question 6, why are you seeking new counsel?_____
_____
_____

8. Describe in your words what medical treatment, prescription medication, or other health care provider-related actions caused your injuries, and describe the extent of your injuries:
_____

9. How has this injury impacted your ability to earn a living (include how much you believe it caused you to lose)?

10. What was you annual income before the incident?

11. What is your annual income now?

If you schedule an appointment to speak to an attorney, please bring to your appointment any supporting documents, including medical reports and receipts showing lost wages or out-of-pocket expenses incurred due to the incident.