QUESTIONNAIRE

Please answer the questions that apply to you or your dependent's treatment. If any of the information requested is not applicable, you do not need to fill out that section. Please return this questionnaire regardless of your response.

Name: _____ Date:_____

Preferred Contact Number: (_____) _____ - _____ Email:_____

Were you or your dependent treated due to any injury or accident? Yes____ No____

- A. If no, what was the cause of the treatment? _____
- B. If yes, please answer the following:

• What was the exact date of the accident? _____

• What were the injuries? _____
_____

• Is treatment ongoing for the injuries? Yes____ No_____

• Was the accident work related? Yes____ No____ If so was a worker's compensation claim filed?

Yes____ No ____

• Was an automobile involved and if so what happened? _____
_____

• If the treatment was not work related or due to an auto accident, then how did the injury happen and on whose property did the injury occur? _____
_____

• What is the name of the company or person at fault for the injury? _____

1. The contact information of your Auto or Insurance Company in this matter, if any:

Name _____

Claim No. _____

Adjuster _____

Tel. No. _____

2. The name of the attorney in this matter, if any:

Name: _____

Tel. No._____

3. The other party's Auto or Insurance Company contact information:

Name _____

Claim No. _____

Adjuster _____

Tel. No. _____

4. If a Worker's Compensation Claim was filed, the Insurance Company contact information:

Name _____

Claim No. _____

Adjuster _____

Tel. No. _____