



HOGANWILLIG
ATTORNEYS AT LAW

MEDICAL MALPRACTICE QUESTIONNAIRE

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

BEST TIME TO CALL: _____

EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT HOGANWILLIG?

PRIOR EXPERIENCE

WORD-OF-MOUTH REFERRAL

INTERNET SEARCH

GOOGLE

YAHOO

OTHER: _____

OTHER: _____

EMPLOYMENT INFORMATION:

EMPLOYER: _____ PHONE #: _____

POSITION: _____ HOW LONG HAVE YOU WORKED HERE? _____

TIME LOST FROM WORK DUE TO INJURY: _____

MEDICAL INSURANCE INFORMATION:

HEALTH INSURANCE CARRIER: _____ ID #: _____



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INJURY/INCIDENT INFORMATION:

DATE OF INCIDENT: _____

LOCATION OF INCIDENT: _____

PLEASE BRIEFLY DESCRIBE THE MALPRACTICE:

PLEASE BRIEFLY DESCRIBE YOUR INJURIES:

PLEASE BRIEFLY DESCRIBE CONTINUED MEDICAL PROBLEMS: _____

PLEASE BRIEFLY DESCRIBE ANY LIMITATIONS YOU HAVE AS A RESULT OF THIS INCIDENT:



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TREATING PHYSICIAN INFORMATION:

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ DATE OF LAST APPT: _____

ADDITIONAL TREATING PHYSICIAN NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ DATE OF LAST APPT: _____

ADDITIONAL TREATING PHYSICIAN NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ DATE OF LAST APPT: _____

PLEASE BRIEFLY DESCRIBE YOUR CURRENT FOLLOW-UP CARE AS A RESULT OF THE ACCIDENT:

ADDITIONAL COMMENTS:

