

SLIP AND FALL

PLEASE PRINT

Date _____ Referred by _____

Name _____ Phone# _____

Address _____ City _____ St _____ Zip _____

Date of Birth _____ S.S.# _____

Medical Insurance? yes no Who? _____

Employer _____ Occupation _____

Address _____ City _____ St _____ Zip _____

Phone # _____ Days & Hrs _____ Wage Loss _____

OFFICE USE ONLY

Date of Accident _____ Place of Accident _____

Lighting--Good _____ Fair _____ Poor _____

Photos Taken? yes no Incident Report Taken? yes no

Description of Accident _____

Witnesses _____

Injuries _____

Ambulanced? yes no Hospital _____

DOCTORS

NAME

ADDRESS

Total Medical So Far \$ _____ Other Losses? _____

Total Wage Loss \$ _____

Previous Injuries? If yes, what? _____

Previous lawsuits? If yes, what? _____

[] Insurance Company [] take photos [] Copy of Incident Report