LAW OFFICES OF ROBERT T. BLEDSOE

DATA INPUT INFORMATION FORM

This information form will allow us to create a data base and an initial computer file assisting us to efficiently continue with the `Intake' process and procedures.

REMEMBER TO SAVE THE DOCUMENT AFTER FILLING IT OUT

PLEASE ENTER ALL INFORMATION IN THE FIELDS PROVIDED

1) Title: Mr. ◉ Ms. ○ Mrs. ○ 2) Email: _____

3) First Name: _____

4) Middle Initial: _____

5) Last Name: _____

6) Mailing Address: _____

7) City, State, Zip code: _____

8) Primary _____ Phone #: _____ Cell #: _____

9) WC Insurance Carrier: _____

10) Claim Adjuster's Name: _____

11) Ins. Company Address: _____

12) City, State, Zip code: _____

13) Carrier's phone #: _____

14) Claim Number(s): _____

15) Date of Injury: _____

16) Body part Injured: _____

17) Your Date of Birth: _____ 18) Social Security Number: _____

19) Employer: (at time of injury) _____

20) Employer's Address: _____

21) City, State, Zip code: _____

22) Job Title: _____ WCAB Number: _____

23) Primary Doctors Specialty (ie: Chiropractor): _____

WORKERS' COMPENSATION QUESTIONNAIRE

Please PRINT your answers to the following questions; answering ALL questions in order for us to fully evaluate your need for legal representation and assistance with any Workers' Compensation claims.
If your need additional space to fully answer a question simply use the reverse side of the page indicating the question's number/letter and continue printing your complete answer to the question asked.

1 GENERAL INFORMATION:

Your Legal Name: _____, _____ _____ *Today's* Date: _____

Your Social Security Number: _____ Date of Birth _____

How did you hear of our office? _____

Your current mailing address: _____
(Street or POB, city, state, zip code) _____

Physical address, *if different than your mailing address*: _____
_____

Your HOME phone number(s): *(Area code)* _____ / _____

Your CELL phone number: (*Area code*) _____ EMAIL: _____

Please list an additional contact person (*not living with you*) that we could call or contact in cases of urgency or emergency:
Name: _____ relationship; _____

Their Address: _____
Phone Number(s), Email and/or other contact information for this person:

_____

2 EMPLOYMENT INFORMATION:

*(Provide your employer's information where you were working **at the time of the injury**)*

Name of your Employer or Company: _____

Address of the Employer or Company: _____
_____

Address of where you worked, if different from Employer's address; also list the department or division in which you worked:
_____

Phone number(s) of your employer *if known*: _____

Your job title: _____ Date you were hired: _____

Wages/Salary you received: $_____ ○Hourly ○Weekly ○Monthly ○Annually
Did you work full time? ○Yes, 40 hours per week ○No, if worked only part time: how many hours per week? _____
Did you work regular Overtime? ○Yes ○No If yes, how many average hours of Overtime per week?____ Rate: $ _____
Do you belong to a Union? ○Yes ○No If yes, list name and local #: _____
Were you scheduled for a wage increase/raise, work review and/or cost of living wage increase? ○Yes ○No
If yes, *please explain why and the amount of increase*:

_____
_____

Briefly explain your regular job duties and describe the job you were doing at the time of injury:

Did you have a second job that you were working at the time of your Industrial Injury? ◯Yes ◯No
If yes,

Second Employer's Name and Address: _____

Job Title: _____ Date of Hire: _____ Wages: $ _____
Average number of hours worked per week on your second job? _____
Job duties of your second job: _____

PAST EMPLOYMENT HISTORY:

What 'other' employers or companies have you worked for during the last 2 years? __NONE

Employer: _____ City/State: _____

How long did you work there? _____ Pay rate: $_____Job Title: _____

Employer: _____ City/State: _____

How long did you work there? _____ Pay rate: $_____Job Title: _____

Employer: _____ City/State: _____

How long did you work there? _____ Pay rate: $_____Job Title: _____

Are you NOW working with a different Employer or Changed Jobs since your date of injury? ◯Yes ◯No
If yes,
New Employer: _____ City/S tate: _____
Date of hire: _____ Job Title: _____ Rate of pay: $_____

How much time have you missed at work? (List the exact dates, periods or time frames you have been off work due to the industrial injury): _____

3 INJURY INFORMATION:

IF more than one date of injury -Please answer the following questions for each date of injury on back of this page.

Body part(s) injured: _____ Date of injury: _____

Where did the injury occur? *(I.E., Employer's address, On the road, In the field - Include City and Zipcode)*

How did the injury occur? What happened?

Did any other person(s) witness the accident or injury? ◯Yes ◯No ◯Don't know or unsure
If yes, explain who and list name(s): _____

Do you feel that another person(s), faulty machinery, equipment / device malfunction, or an unsafe / improper work environment was responsible for your injury? ◯ Yes ◯ No ◯ Unsure or don't know

Comments: _____

_____

Briefly describe how your injury occurred and what happened: _____

_____

_____

_____

_____

_____

Did you report the injury? ◯ Yes ◯ No If Yes, who did you report the injury to? _____
If No, why? _____

Did the employer or company complete or fill out a claim form or accident report? ◯ Yes ◯ No ◯ Don't Know/Unsure
Did the employer provide you with a completed or filled out copy of a Workers' Comp. claim form? ◯ Yes ◯ No
Do you have a copy of that form to provide to us for review and placement into your file? ◯ Yes ◯ No

4 PRIOR INJURIES

HAVE YOU HAD ANY OTHER PRIOR INDUSTRIAL OR WORKERS' COMPENSATION INJURIES? ◯ Yes ◯ No
If yes, pleas list details: *(Continue on back of this page if more space is needed to answer this question)*

Body Part	*Date of Injury*	*Employer*	*City and State where occurred*

Do any of these injuries still bother you? ◯ Yes ◯ No
Do you have permanent 'Work Restrictions' from prior injuries?

_____

Did any of the prior injuries cause permanent disability?

_____

Are you still receiving and medical treatment or taking prescription medication for the ABOVE prior industrial injuries?
Comments or Explain: _____

_____

_____

_____

Did you receive any monetary settlements for any prior Industrial or Workers' Compensation injuries? ◯ Yes ◯ No
If yes, provide some details: *(List the injury, date of injury, body part involved, type of settlement and the rating, if known)*

_____

_____

_____

_____

5 MEDICAL INFORMATION RELATING TO YOUR WORK INJURY OR ILLNESS:

When your injury first occurred, did you receive immediate medical care? Were you taken the hospital emergency room, or go to a doctor or clinic? Did you receive 'on-site' first aid or assisted by company 'in-house' medical personnel? Answering the above, please explain details of medical care received immediately after your workplace injury with names of doctor(s), clinic and / or name and location of hospital:

_____

_____

_____

Are you still seeing your doctor and receiving medical care? ◯ Yes ◯ No
Who is your current treating physician?
Doctor's Name and/or Clinic: _____ City: _____
Other comments: _____

Who sent you to your current treating physician? ◯ Employer ◯ Insurance Co. ◯ Personal choice
◯ Other: _____
If you were required to select your current doctor, did you select your doctor from:
__ A list or referral form you received from the insurance company.
__ A referral from another doctor or medical professional.
__ A personal referral or personal knowledge of the physician.
Do you plan on staying with your current Doctor during the course of your treatment? (Are you happy with this Doctor?)
◯ Yes ◯ No, I would like to request a change of treating physician, because:

_____

_____

Have you had surgery for this injury? ◯ Yes ◯ No Has surgery been recommended or schedule? ◯ Yes ◯ No
Has the Doctor found you Permanent & Stationary, or released you to return back to work? ◯ Yes ◯ No

Do you have any type of medical insurance, either employer-provided group medical coverage or your own private medical insurance? ◯ Yes, (Name of Company) _____
(Medical Number) _____
◯ No
Who has been paying for your medical treatment, tests & medicines relating to your work injury?
__ Workers' Comp. __ Yourself __ Your own medical insurance or your Spouse's Ins. __ Medi-Cal __ Lien basis
__ Other, explain_____
Have you or are you currently having any problems getting the medical bills paid or problems with receiving authorization for medical treatments, tests and/or medications prescribed by your treating physician? ◯ Yes ◯ No
Comments: _____

Have you been given a selection of QME's (Qualified Medical Evaluators) or a form listing evaluating Doctors for you to choose and see? ◯ Yes ◯ No If yes, did you select a QME? ◯ Yes ◯ No If you selected a QME from the panel what was their name? _____

_____

Did you have the evaluation or appointment with the QME doctor? ◯ Yes ◯ No When? Date_____

6 OTHER MEDICAL INFORMATION:

Who is your primary care physician or your family Doctor? (Dr.'s Name, Clinic Name, Address, City/State)

_____

_____

_____

Do you have any serious illnesses? (I.E., diabetes, asthma, arthritis, cancer) ◯Yes ◯No
If yes, explain: _____

Have you had any prior surgeries or been hospitalized? ◯Yes ◯No
If yes, explain listing dates, place and reasons: _____

Have you had any 'non-industrial' injuries, such as car accidents, broken bones, sports injuries, childhood accidents or serious childhood illnesses? ◯Yes ◯No
If yes, explain listing dates, body part(s) and/or type of serious illness:

Do you have any disability, pain, limitations or continued medical problems from the above prior injuries? ◯Yes ◯No
If yes, explain: _____

7 INSURANCE INFORMATION: *(regarding your current work injury)*

What is the name of the Insurance Company (Workers' Comp. Carrier) handling this work injury for your Employer?

Name: _____

Address: _____

City, State, Zip: _____

Phone number: _____

Claim Number: _____

The claim's adjuster or contact person at the insurance company: _____

Has the insurance company or their attorney contacted you either by phone or letter? ◯Yes ◯No
If yes, do you remember when and who you talked with?

Has the adjuster, investigator, or an attorney taken a statement from you regarding the injury? ◯Yes ◯No
If yes, what do you remember about the questions and your answers (or any other comments you would like the attorney to know):

Has the insurance company or their representative have you sign any type of document(s)? ◯Yes ◯No
If yes, explain: _____

Has anyone representing this insurance company offered any type of proposed settlement? ◯Yes ◯No

If yes, explain: _____

Have you received any payments or checks identified as 'Permanent Disability' (PD), or 'Permanent Partial Disability' (PPD), or 'Permanent Disability Advance' (PDA)? ◯Yes ◯No

If yes, approximately how much money in permanent disability checks have you received thus far? $_____

8 OTHER REQUIRED INFORMATION:

Disability Payments:

Temporary Disability (TD) payments

How much work time have you missed because of your work injury? _____

Are you still off work per doctor's orders? ◯Yes ◯No

Did you receive Temporary Disability Payments? ◯Yes ◯No
Have you been paid for ALL the time you missed from work thus far? ◯Yes ◯No

If you received TD, what was the weekly amount paid? $_____

Are you receiving these TD payment currently? ◯Yes ◯No
If NO, when did they stop? _____
Do you know the reason disability payments have stopped? _____

State Disability Insurance (SDI) payments.

Are you receiving SDI benefits currently? ◯Yes ◯No
If yes, the amount being paid weekly: $_____
Did you ever apply for SDI payments because of this work injury? ◯Yes ◯No
Comments: _____

Have you applied and/or received or currently receiving any other benefits related to your work injury? Such as accrued vacation time/pay, sick time/pay or Social Security, SSI, retirement benefits, Long Term or Short Disability payments, salary continuation, or any other payments because of your industrial injury or illness….Please explain or comment regarding other benefits or funds:

_____

_____

_____

Other Attorney contact(s):

Have you consulted with another attorney about this work injury or illness before today? ◯Yes ◯No
If yes, please provide the attorney's name and address: _____

_____

Reason for the prior consultation with another attorney:
(such as Third Party, Wrongful Termination, Discrimination, Faulty equipment, machinery or tools, medical malpractice or for advice on this Workers" Compensation claim) _____

_____

_____

Did you agree to representation or sign ANY paperwork? ◯Yes ◯No

Have you filed with EEOC or an ADA Claim? ◯ Yes ◯ No if yes, explain:

_____

_____

Have you filed a Union grievance? ◯ Yes ◯ No if yes, explain: _____

_____

SOCIAL SECURITY

Have you applied for Social Security Disability Insurance (SSDI)? ◯ Yes ◯ No
If yes, what is the status of your claim? _____

_____

Are you <u>currently</u> receiving Social Security Disability Insurance (SSDI) payments? ◯ Yes ◯ No
If yes, are you receiving Medicare? ◯ Yes ◯ No
Comments, if any: _____

ENGLISH LANGUAGE

Is English your primary language? ◉ Yes ◯ No if No, What is your primary language: _____

If English is not your primary language, do you feel you will need an interpreter for legal proceedings? ◯ Yes ◯ No

Please Note:
If you feel you do not read, speak and write in English effectively an interpreter can be arranged for legal proceedings, depositions and medical evaluations...BUT understand you will be required to bring a friend, family member or another person with you for all of your meetings with your attorney or other contacts with this office that is able to efficiently speak, read and write English, You must also provide a name and phone contact of someone speaking English that this office could contact by phone regarding your case.

<u>Please sign</u> in agreement: _____

Name of person(s) to contact that will assist in translation:

_____

Relationship:_____ Their phone number(s): _____

Any other contact information that would enable this office to communication with you:

_____

_____

Do you have any other 'IMMEDIATE' concerns or urgent questions you need answers to?

_____

_____

_____

You may use this space for other information not covered within the questionnaire or any facts that you wish the attorney to consider and be contained your file:

_____

MEDICAL INFORMATION ADDENDUM

PROVIDE THE NAMES AND LOCATION OF ALL PHSICIANS, CLINICS, HOSPITALS AND PLACES YOU HAVE BEEN SEEN OR TREATED FOR THIS WORK INJURY

TREATMENT:

NAME	*ADDRESS*	*PHONE*

MRI, XRAY, LAB WORK:

CONSULTATIONS, EVALUATIONS:

OTHER:
