Date of Injury:______/_______/____________

Client: _____________________________________

IMPORTANT:

We must have the information in this survey to complete your claim!

Please complete this survey and return it to us within the next **10 days**.

PRE-ACCIDENT SURVEY #1

1. Work Background	Section
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2. Health and Hospitalization History	Section
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Medical Insurance	3.1

1. EMPLOYMENT HISTORY

1.1 Employment at the Time of Your Accident

Employer: ____________________

Address: ____________________ City: ____________________ State: ________ Zip: ________

Job Title: ____________________ Date employment began: _____/_____/_____

Salary Rate of Pay: $____________ Per: ________ How many hours per week: ________

Hourly: $____________ Per: ________ How many hours per week: ________

Benefits: ____________________

Amount you earned in the last full year before your injury: $____________ Did you receive a W-2: ☐ Yes ☐ No

Have you filed Income Tax Returns for the last 5 years: ☐ Yes ☐ No Do you have copies: ☐ Yes ☐ No

1.2 Five Year Employment History

Most recent employer BEFORE your current one: ____________________

Employer: ____________________

Address: ____________________ City: ____________________ State: ________ Zip: ________

Dates of Employment: From: _____/_____/_____ To: _____/_____/_____

Nature of Work: ____________________

Salary Rate of Pay: $____________ Per: ________ How many hours per week: ________

Hourly: $____________ Per: ________ How many hours per week: ________

Benefits: ____________________

Next most recent employer: ____________________

Address: ____________________ City: ____________________ State: ________ Zip: ________

Dates of Employment: From: _____/_____/_____ To: _____/_____/_____

Nature of Work: ____________________

Salary Rate of Pay: $____________ Per: ________ How many hours per week: ________

Hourly: $____________ Per: ________ How many hours per week: ________

Benefits: ____________________

1.3 Spouse's Employment

Is your spouse presently employed: ☐ Yes ☐ No If yes, please furnish the following:

Name of employer:______________________________

Address: ____________________ City: ____________ State: _____ Zip:______

Present job title: ____________________ Date hired: ____/____/____

Salary Rate of Pay: $____________ Per: ________ How many hours per week: ________

Hourly: $____________ Per: ________ How many hours per week: ________

Benefits:______________________________

2. HEALTH AND HOSPITALIZATION HISTORY

2.1 Past Hospitalizations Before Your Accident

Were you EVER AT ANYTIME received treatment at a hospital BEFORE this accident for any reason: ☐ Yes ☐ No
If yes, please complete the following:

Most recent hospital treatment BEFORE the accident:____________________

Address: ____________________ City: ____________ State: _____ Zip:______

Reason for Hospital treatment: ____________________

Length of Hospital treatment: From: ____/____/____ To: ____/____/____

Next hospital treatment BEFORE the accident:____________________

Address: ____________________ City: ____________ State: _____ Zip:______

Reason for Hospital treatment: ____________________

Length of Hospital treatment: From: ____/____/____ To: ____/____/____

Next hospital treatment BEFORE the accident:____________________

Address: ____________________ City: ____________ State: _____ Zip:______

Reason for Hospital treatment: ____

Length of Hospital treatment: From: _____/____/________ To: ______/____/_________

2.2 Past Illnesses

BEFORE this accident, did you have had ANY long-lasting, chronic or serious illnesses for which you sought medical treatment? ☐ Yes ☐ No If yes, please complete the following:

Doctor: ______________________________ City: ____________________ State: _____

Date: ____/____/______ Nature of Illness: ____

Doctor: ______________________________ City: ____________________ State: _____

Date: ____/____/______ Nature of Illness: ____

Doctor: ______________________________ City: ____________________ State: _____

Date: ____/____/______ Nature of Illness: ____

2.3 Accidents, Broken Bones or Injuries Before This Accident

BEFORE this accident did you have any injuries or medical conditions of any kind which required medical attention? ☐ Yes ☐ No If yes, please furnish the following information:

Doctor: ______________________________ City: ____________________ State: _____

Date: ____/____/______ Nature of Accident: ____

Injury: ____

Doctor: ______________________________ City: ____________________ State: _____

Date: ____/____/______ Nature of Accident: ____

Injury: ____

Doctor: ______________________________ City: ____________________ State: _____

Date: ____/____/______ Nature of Accident: ____

Injury: ____

2.4 Past Medical/Dental Information

In the **FIVE** YEARS BEFORE YOUR ACCIDENT, who has been your regular family doctor and dentist that you have consulted when you needed medical attention? If more than one doctor, dentist, osteopath, chiropractor, or other physician has been used by you, please indicate below.

Primary Care Doctor:________________________________ Dates Seen: __________ through __________

Address: ________________________________ City: _____________________ State: ____ Zip:________

Reason(s) for treatment: ____

Dentist:____ Dates Seen: __________ through __________

Address: ________________________________ City: _____________________ State: ____ Zip:________

Reason(s) for treatment: ____

Other Dr. or Health Care Provider:______________________ Dates Seen: __________ through __________

Address: ________________________________ City: _____________________ State: ____ Zip:________

Reason(s) for treatment: ____

Did you use any drugs or medications regularly (more than one refill) BEFORE your accident: ☐ Yes ☐ No

If yes, please name each drug or medication and its purpose:

Drug:___________________________ Purpose:____

Drug:___________________________ Purpose:____

Drug:___________________________ Purpose:____

Drug:___________________________ Purpose:____

Have you EVER had any auto, life or health insurance declined or canceled: ☐ Yes / ☐ No If yes, please indicate which and, give the date and reason:

☐ Auto: Date: ______/______/_________ Reason:____

☐ Life: Date: ______/______/_________ Reason:____

☐ Health: Date: ______/______/_________ Reason:____

3. INSURANCE INFORMATION

3.1 Medical Insurance

Do you have any medical insurance policies, including any medical insurance through your employment, or a private medical policy: ☐ Yes ☐ No If so, please furnish the following information:

Name of Insurance Company:____

Address: ____________________________________ City: ______________________ State: ____ Zip:________

Insurance Agent, if any:______________________________ Policy Number:_____________________________

Who pays for this coverage:____

Have you made any claim for payment of your accident-related medical bills from:

Your medical insurance: ☐ Yes ☐ No Medicaid/Medicare: ☐ Yes ☐ No

Other insurance company: ☐ Yes ☐ No Other sources: ☐ Yes ☐ No

If any of your accident related medical bills been paid by a health insurance company, Medicaid, Medicare or any person other than yourself, please furnish the following information:

Name of entity paying bills:____

Name of entity paying bills:____

Name of entity paying bills:____

Do you have any insurance of any kind which would provide disability payments: ☐ Yes ☐ No If yes, please furnish the following information:

Name of Insurance Company:____

Address: ____________________________________ City: ______________________ State: ____ Zip:________

Insurance Agent: _______________________________________Phone No: _______________________________