Medical Malpractice Intake Form

Date of first contact:

Name & Address

NAME:	
Address:	Telephone Numbers: Home: Work: Cell:
SSN#:	Date of Birth:

Referred by:

Prior Counsel?

Doctors/Facilities Involved

1.	2.
3.	4.
5.	6.

Description of issue:

Date of Discovery of injury due to malpractice

Prior Injuries or Health Issues? ☐ Yes ☐ NO

When?
What were the injuries?
Are you a Medical Marijuana user?

Client's Health Insurance

Name of Company: Contact Information	Member ID: Group Number:

Form Completed by: