STANDEFFER LAW, LLC

MEDICAL MALPRACTICE
CLIENT QUESTIONNAIRE

If extra room is needed for answering any of the questions below, please attach sheet of paper to questionnaire with number of section you are answering

Date form completed:____________________________________

SECTION 1
(This section should be completed with information for the victim of the alleged medical malpractice).

Victim/Decedent's full name____

Address____County________________

City __________________________________State__________________Zip ___________________________________

Telephone (home)________________(work)________________(cell)______________________

Email____

Social Security No.____________________________Date/Place of Birth_____________________________________

Employer____

Employer Address____

Position Held____

Name, address, and telephone number of person to contact in case of emergency:_____________________

____

Name of Victim's Spouse_______________________________Spouse Date of Birth____________________

Spouse's Social Security Number________________________Date Married___________________________

Spouse's telephone number (home)_____________________________(work)___________________________________

Spouse's employer & position held____

VICTIM'S CHILDREN

Name	Address	Age

SECTION 2
(This section should be completed with information for the individual retaining Harbin & Burnett L.L.P. to investigate the alleged medical malpractice).

Client's full name____

Relationship to victim____

Address____County________________

City ________________________State________________Zip ________________________

Telephone (home)________________(work)____________________(cell)____________________

Email________________________________

Social Security No.________________________Date/Place of Birth________________________

Employer____

Employer Address____

Position Held____

Name, address, and telephone number of person to contact in case of emergency:__________________

____

Spouse's Name________________________Spouse Date of Birth__________________

Spouse's Social Security Number____________________Date Married____________________

Spouse's telephone number (home)________________________(work)________________________

Spouse's employer & position held____

CHILDREN

Name Address Age

____

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SECTION 3

(A) If the victim is deceased, has an estate been opened? If so, please attach a copy of the Certificate of Appointment showing who is responsible for the Estate.

Date of death_________________________

Name of Personal Representative_______________________

(B) If the victim was under 18 years of age, please complete the questions below:

Father's name:____

Mother's name:____

If parents of minor are divorced or separated, list the custodial parent's name, address and phone number:________
____

(C) If victim is incompetent to handle his/her own affairs, has someone been appointed guardian or conservator for the victim? If so, give, name, address, and phone number of person appointed and send copied of documents showing the appointment.

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SECTION 4

Have you conferred with any other attorney regarding your complaint of medical malpractice?
Yes_________ No________. If answer is yes, please state with whom you conferred and whether you have signed a fee contract with that attorney.______________________________

Where did you hear about this firm:
Attorney______________________ Friend_____________________________

Yellow Pages: Yes No If yes, which telephone book?_______________

Television: Yes No If yes, which channel?______________

Other____
Have you been involved in any previous lawsuits? Yes___________ No______________

If answer is yes, please state details:____

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Have you ever been arrested? Yes________ No________________

If answer is yes, please state details: ____

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SECTION 5

Date of incident which led you to believe medical malpractice was committed ______________________

What made you think the doctor, hospital employees or other health care providers may have been guilty of medical malpractice? ____

List all doctors and/or hospitals who you feel committed medical malpractice:

Name of Doctor or Hospital ____

Address ____

Dates of Treatment ____

Reason for Treatment ____

Complications ____

Name Treated Under ____

Date of Last Treatment ____

*****

Name of Doctor or Hospital ____

Address ____

Dates of Treatment ____

Complications ____

Name Treated Under ____

Date of Last Treatment ____

Has any doctor, hospital employee or other health care provider told you there was negligence involved in the treatment?
Yes ______________________________________ No __________

If answer is yes, please state name, address and telephone number of person and the details of your conversation _
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SECTION 6

List family members or friends who can furnish us information which may be helpful in evaluating the case:

Name____

Address____

Home Telephone____

Work Telephone____

Cellular Telephone____

Relationship to victim____

*****

Name____

Address____

Home Telephone____

Work Telephone____

Cellular Telephone____

Relationship to victim____

*****

Name____

Address____

Home Telephone____

Work Telephone____

Cellular Telephone____

Relationship to victim____

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SECTION 7

List all doctors and hospitals who treated the victim as a result of the malpractice including the ones who may have committed malpractice:

Name of Doctor or Hospital ____

Address ____

Dates of Treatment ____

Complications ____

Name Treated Under ____

Date of Last Treatment ____

*****

Name of Doctor or Hospital ____

Address ____

Dates of Treatment ____

Complications ____

Name Treated Under ____

Date of Last Treatment ____

*****

Name of Doctor or Hospital ____

Address ____

Dates of Treatment ____

Complications ____

Name Treated Under ____

Date of Last Treatment ____

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SECTION 8

Did medical insurance pay any of the medical bills?

No Yes

Please state name and address of the provider:____

Was the patient receiving benefits from Medicare? No Yes
Medicare ID Number ______________________________

Was the patient receiving benefits from Medicaid? No Yes

Medicaid ID Number ______________________________

Was the patient receiving benefits from the Veterans' Administration? No Yes

VA ID Number ______________________________

What are the approximate total medical bills as a result of the malpractice? $ ______________________

Did the victim miss any work as a result of the medical malpractice?

No Yes

If answer is yes, total amount of lost wages $ ______________________________

List any other expenses or damages as a result of the alleged medical malpractice. ______________________________

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SECTION 9

Is there any other information you feel we need to know to assist us in evaluating the medical malpractice case? Yes No
If answer is yes, please state details:

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