TORT

GENERAL INFORMATION SHEET

1. Personal and Family History

Full Name_____

Present Home Address_____

_____

Present Business Address_____

_____

Home Phone_____ Business Phone_____

Contact person (if we cannot reach you and we must get a message to you):_____

_____

Address:_____

_____

Phone:_____

Automobile Insurance Carrier and Policy Number:_____

Health Insurance Company and Group/Member Number(s):_____

Secondary Health Insurance Company and Group/Member Number(s):_____

Medicare HIC number:_____

"Umbrella" Insurance Carrier and Policy Number:_____

Disability Insurance Carrier and Policy Number:_____

2. Date of Injury or Accident_____

(If you are not certain about a specific date, please discuss this with the lawyer ***immediately****.)*

Location of Accident/Injury_____

Did you call 9-1-1? ____

Did you or anyone else take photographs of the accident scene? ____ If so, who? _____

Did you or anyone else take photographs of your injuries? If so, who?_____

Have you given a recorded statement to anyone - insurance adjuster, police, investigator? ____

If this involves a motor vehicle accident, did you submit a traffic crash report to Oregon DMV? ____

Did you have a mobile phone at the time of your injury? ____ If so, have you preserved the billing records – regardless of whether you were using the phone at the time of injury? ____

Names of other people involved in the Accident/Injury:

_____

_____

_____

3. Have you ever used, or been known by, any other name than that shown above? If so, list here each such other name, and state when and why such other name was used:

_____

_____

4. State the addresses where you have resided during the past ten years, and the period of time at each residence, including dates:

_____

_____

5. Place of birth_____ Date_____

Have you ever used any other date or place of birth?_____

If so, give details:_____

6. Are you married?_____

Date of marriage_____ Place of marriage_____

Full name of spouse_____

Have you ever been divorced or legally separated? ☐Yes ☐No
If so, please specify names, dates, and the state the divorce or separation was filed._____

7. List the names, ages, and addresses of all those (including children) who depend upon you for support, and your relationship to each:

NAME	ADDRESS	AGE	RELATIONSHIP

8. What year did you last file an income tax return?_____

9. Employment History:

Social Security Number_____

a. Most Recent Employer _____

Employer's Address _____

Ending date _____ Beginning date _____

Job Classification _____

Beginning pay rate _____ Ending pay rate _____

Have you missed any time from work because of your injury? _____

If so, list the dates you could not work:

FROM	TO

Reason(s) for leaving _____

_____

_____

b. Employer prior to last listed _____

Employer's address _____

Ending date _____ Beginning date _____

Job classification _____

Beginning pay rate_____ Ending pay rate_____

Have you missed any time from work because of your injury?_____

If so, list the dates you could not work:

FROM	TO

Reason(s) for leaving_____

_____

_____

c. Employer prior to last listed_____

Employer's address_____

Ending date_____ Beginning date_____

Job classification_____

Beginning pay rate_____ Ending pay rate_____

Have you missed any time from work because of your injury?_____

If so, list the dates you could not work:

FROM	TO

Reason(s) for leaving_____

_____

_____

10. Educational Background

What education have you had, including any special job training?_____

_____

_____

_____

11. Military Background

Have you ever been rejected for military service because of physical, mental, or other reasons?_____

If so, explain:_____

_____

Have you been in the military service?_____

If so, give service number_____

Type of discharge_____

Dates of service_____

Have you any service-connected injuries or disabilities?_____

If so, give details:_____

_____

Percentage of disability_____

Present condition of service-connected injury or disability_____

_____

12. Prior Claims and Lawsuits

Many cases have been damaged beyond repair by a history of other claims and lawsuits which your attorney did not know about. It is **NOT** the fact that one has had other claims or a lawsuit that is important, for one will not be penalized by a court or jury if the claims are reasonable and genuine. It is the **DENIAL** of previous claims and suits that damages the case. List every claim you have ever made for personal injury or property damage, and give details:

a. Date_____ Nature of Claim_____

Against whom_____ Suit filed?_____

Result_____

b. Date_____ Nature of Claim_____

Against whom_____ Suit filed?_____

Result_____

c. Date_____ Nature of Claim_____

Against whom_____ Suit filed?_____

Result_____

13. Police Record

It is the law in this state, and elsewhere, that if a person has a criminal record, no matter how long ago, no matter how mitigating the circumstances, that fact may be proven against the person and commented on at trial. Most defense attorneys will **Not** bring up a person's criminal record if they believe the facts will be readily **Admitted** when asked, since to do so will hurt, rather than help, the defense. However, if they believe that conviction for a crime will be **Denied** when the fact is otherwise, they **Will Not Hesitate** to use it against you. The defense will make a complete investigation of your background, and we must be **Prepared Against** the development of unfavorable evidence. List here any arrest and state the date, place, charge, and result:

_____

_____

_____

_____

_____

14. Workers' Compensation

Have you made a claim for Workers' Compensation?_____

If so, when was the date of your injury?_____

Are you receiving Workers' Compensation payments?_____

If so, explain:_____

_____

Who is handling your Workers' Compensation action?_____

_____

15. Are you presently receiving benefits or health insurance coverage from any source other than Workers' Compensation?

Social Security Disability	☐Yes ☐ No
Welfare	☐Yes ☐ No
Medicare	☐Yes ☐ No
Oregon Health Plan	☐Yes ☐ No
Medicaid	☐Yes ☐ No
Supplemental Security Income	☐Yes ☐ No
Crime Victims Compensation Fund Benefits	☐Yes ☐ No
Private Long-Term Disability Benefits	☐Yes ☐ No
Food Assistance (food stamps)	☐Yes ☐ No

If so, explain:_____

_____

_____

16. Prior Physical Examinations

List here **EVERY** physical examination you have ever had during the last ten years, for any purpose, including employment, promotion, insurance, selective service, armed forces, etc. State date, name of doctor, and result, as fully as you can recall.

a. Date_____ Place_____

Name of doctor_____

Purpose_____

Result_____

b. Date_____ Place_____

Name of doctor_____

Purpose _____

Result _____

c. Date _____ Place _____

Name of doctor _____

Purpose _____

Result _____

d. Date _____ Place _____

Name of doctor _____

Purpose _____

Result _____

e. Date _____ Place _____

Name of doctor _____

Purpose _____

Result _____

17. Prior Accidents and Injuries

Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem. List here every such incident, whether it resulted in a claim for damages or not, stating the date, place, nature of the accident and extend of your injuries. If none, so state:

_____

_____

_____

_____

18. Illness or Disease

No matter how trivial an illness, either before or since your accident, we must know about it. This is particularly true if there is any connection with your present physical complaints. The defendant will have available at the trial, by medical and hospital records, veteran's records, insurance records, etc., a complete history of your past physical condition.

a. Date_____ Nature of illness_____

Duration_____ Treated by_____

Hospitalized?_____ If so, give dates:_____

Name and address of hospital_____

_____

b. Date_____ Nature of illness_____

Duration_____ Treated by_____

Hospitalized?_____ If so, give dates:_____

Name and address of hospital_____

_____

c. Date_____ Nature of illness_____

Duration_____ Treated by_____

Hospitalized?_____If so, give dates:_____

Name and address of hospital_____

_____

Do you now or have you ever had trouble with: eyes _____ears _____
If so, give details:_____

_____

Have you ever worn glasses?_____an artificial eye? _____a hearing aid?_____

If so, give details:_____

_____

Have you ever worn a brace, or back or neck support?_____

If so, give details:_____

_____

Have you ever worked with radioactive substances, asbestos; or any other substance alleged to cause diseases, such as cancer?_____

_____

Have you ever been denied life or health insurance?_____

If so, by which company and why?_____

_____

19. Alcoholism, Drug Addiction, and Venereal Diseases

If you have ever been treated for these conditions, please discuss it with your attorney **Confidentially**, long before your case goes to trial.

20. The Injury

State all injuries known to result from the accident:

Describe how your injuries have affected your life:

Continue on Additional Pages if Necessary

Length of time confined to bed

Length of time confined to house

State present physical condition, including scars, disabilities, deformities, discomforts, etc., due to the injuries:

21. List all physicians and surgeons you have seen for your injury/injuries:

a. Name

Address

Nature of Treatment _____

Still under care? _____

b. Name _____

Address _____

Nature of Treatment _____

Still under care? _____

c. Name _____

Address _____

Nature of Treatment _____

Still under care? _____

d. Name _____

Address _____

Nature of Treatment _____

Still under care? _____

e. Name _____

Address _____

Nature of Treatment _____

Still under care? _____

Continue on Additional Pages if Necessary

22. Did this accident occur at a ski facility? _____

23. Did this accident involve consumption of alcohol on your part or on the part of the defendant(s)?

_____

24. List all nurses, therapists, or other health care professionals that you have seen:

a. Name _____

Address _____

Nature of Treatment _____

Still under care? _____

b. Name _____

Address _____

Nature of Treatment _____

Still under care? _____

c. Name _____

Address _____

Nature of Treatment _____

Still under care?_____

Continue on Additional Pages if Necessary

25. Have you ever filed bankruptcy? Are you considering filing for bankruptcy? Personal injury claims must be fully disclosed in bankruptcy and included as an asset on Schedule A/B (Personal Property Schedule). Failure to disclose a personal injury claim in bankruptcy can result in permanent dismissal of your claim.

_____

_____

Continue on Additional Pages if Necessary

26. Have you kept a diary or journal since your injury? ☐Yes ☐ No

27. Do you blog or maintain a Web site? ☐Yes ☐ No

28. Do you use Social Networking sites, such as Twitter, Facebook, or Instagram? ☐Yes ☐ No

AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ [Name of person/entity disclosing information] to use and disclose a copy of the specific health information described below regarding:

_____[Name of individual] consisting of: [Describe information to be used/disclosed] _____

_____

_____

to: [Name]_____

[Address]_____

[City] _____[State]_____[Zip]_____

for the purpose of: [Describe each purpose of disclosure or indicate that the disclosure is at the request of the individual]: _____

_____

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree this information will be disclosed if I place my initials in the space next to the type of information.

_____ HIV/AIDS information

_____ Mental health information

_____ Genetic testing information

_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed under this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not hurt your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely to provide health information to someone else and the authorization is necessary to make that disclosure.

MEDICAL AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (Release of Medical Records)

I, _____ (DOB: _____) authorize [*Provider's Name*]:

_____

to disclose my health information as identified below to [*Name of Attorney*] for the purpose of representing me in litigation related to a personal injury.

By initialing in the spaces below, I specifically authorize the disclosure of this health information and records:

____ Entire medical record (all information)

____ Billing record

____ Records developed between _____ to present.

If the information to be disclosed contains any of the following types of information or records listed below, additional laws relating to disclosing this information may apply. I agree the following categories must be initialed to be included in this authorization to release information.

____ ***HIV/AIDS related health information/records

____ *** Mental health information/records

____ *** Genetic testing information/records

____ *** Drug/alcohol diagnosis, treatment and/or referral information. [Federal law prohibits the Re-disclosure of this information. Describe what kind and how much information should be included to comply with federal law: _____

____+++Psychotherapy notes [+++If authorization is for disclosing psychotherapy notes, it cannot be combined with any other authorization.]

Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. Unless revoked earlier, this authorization will terminate on _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information disclosed under this authorization.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I understand that the person(s) I am authorizing to disclose my information may receive compensation for doing so.

_____

(Signature of patient or person authorized by law)

_____ _____

Date

A Copy of This Authorization Shall Be Just as Valid as the Original

[*Firm Letterhead*]

[*Date*]

Re: [*Client Name*]
[*Social Security Number*]

Dear [*Name*]:

AUTHORIZATION TO RELEASE EMPLOYMENT RECORDS

I certify that [*Name of Attorney*] represents me. I waive any privilege I may have and authorize my attorneys, their employees, or designees to inspect and/or copy any records of any nature pertaining to me. You are authorized to furnish information relating to my employment and to render reports to my said attorney, upon receipt of this Authorization.

Any Authorizations to Any Other Parties Executed by Me are Hereby Revoked.

I respectfully request:

☐ A complete copy of my personnel file.

☐ Verification of employment, reflecting my date(s) of employment, position held, and current or last applicable wage.

☐ Calculation of the lost wages I incurred due to my accident on [*Date of Accident*]. Please list all time missed from work due to the accident along with the wages I would have earned had I been able to work.

☐ Other_____

_____

By:_____

IMPORTANT NOTICES

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