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 |
|  |  |
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|  |  |

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

If you have a criminal record, it is not clear whether your criminal record will be used against you. In any event, we cannot protect you against wrongful use of your criminal record if we do not know whether you have such a record. Using the section below, list any arrest, and write the date, place, charge, and result of the arrest; do this even if you had your record expunged, and no matter how long ago the arrest and result of the arrest occurred.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

29. Have you texted, e-mailed, or otherwise written to anyone 🞎Yes 🞎 No

about the accident or your injury?

30. Have you deleted e-mails or text messages or destroyed other 🞎Yes 🞎 No

written forms of communication related to the accident or your injury?

**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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