CAMERON D. SIMPSON, P.A.

Personal Injury Plaintiff Information

(Please print clearly) Today's Date _____

Full Name _____
Date of Birth_____ SSN#_____
Street Address_____
City, State, Zip Code _____
Home Phone ( )_____Cell Phone( )_____
Work Phone ( )_____ E-Mail _____
Employer_____ Occupation_____
Name of Spouse_____ Number of Dependents_____
Nearest relative/friend not living with you or emergency contact_____
Telephone No._____
Name of your Insurance Co._____
Address_____
Telephone No._____Claim No._____
Do you have any Arrests/Criminal/Felony convictions?_____ If so when, where, what for?_____

Date of your Incident _____Place of Incident_____
Describe Incident in detail_____
_____
_____
Person/Company Responsible_____
Address_____
Telephone No._____
Name of Person/Company Responsible Insurance_____
Address_____
Telephone No._____Claim No._____
Nature of Injuries_____
_____
Have you had surgery as a result of this incident?_____ If Yes, When? _____
What type of surgery?_____
Did you go to the Emergency Room as a result of this incident?_____
Name of Hospital/Address_____
Names of Physicians that have treated you for this injury_____
_____
Current Medications_____
Did you consume any alcoholic beverages or take any drugs or medication within twelve hours of the incident?_____ If Yes, state the type and amount
_____
Do you have any prior/preexisting medical conditions? If so, what type?_____
_____

Who referred you or how did you hear about our firm? a) Billboard b) Yellow Pages c) Friend/ Former client d) Legal Shield e) AVVO f) Internet Search g) FL Bar h) Doctor i) Other, Please tell us _____

Personal Health Insurance Information

Worker Compensation and Personal Injury only

Name:_____ Date:_____

Current Health Insurance Carrier:_____

Secondary Health Insurance Carrier:_____

_____ Copy of driver licenses or military ID

_____ Copy of health insurance card(s)

If Medicare/Medicaid- Please sign

_____ Consent to Release Information (you are the beneficiary)

_____ Proof of Representation (you are the beneficiary)

_____ Authorization for the Use and Disclosure of Personal Health Information

If Tri Care- Please fill out and sign

_____ Statement of Personal Injury