CAMERON D. SIMPSON, P.A.

Social Security Claimant 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._____
Do you have any Arrests/Criminal/Felony convictions?_____If so, when, where, what for?_____

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 _____

Nature of Disability (a)_____
(b)_____
(c)_____
When did you become disabled?_____
When did you file for Social Security?_____
Were you denied benefits?_____If Yes, What was the date of your denial?
_____
What was the name of the form you filed (Request for Reconsideration or Hearing)?
_____
Have you had surgery?_____ If Yes, When? _____
What type of surgery?_____
Name of Hospital_____
Address_____
Name of Physicians treating you for this condition_____
_____
Current Medications_____

Your Place of Birth: City _____ **State**_____

What is your mother's maiden name?