CAMERON D. SIMPSON, P.A.

Workers' Compensation 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 ____________________
Name of Spouse____________________________ Number of Dependents_______
Nearest relative/friend not living with you or emergency contact______________
Telephone No.____
Are you currently employed, if so where ____________________Wages_________
Military Service _____________ Education (include special/technical training) ________
____
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 __________

Date of Accident______________ Location of Accident(City)__________________
Describe Accident and Work being performed when injury occurred ______________
____
____
Parts of the body injured _______________________________________
Do you have any pre-existing injuries/conditions, same body part(s)?____________
If so, please describe ____
What does the injury prevent you from doing (i.e. lifting, twisting, standing, sitting)_______
____
When did pain/disability appear___________________________________
Witness Names ____________________Date employer notified of injury__________
Have you had any prior accidents?______If so, when_________________________
Did you consume any alcoholic beverages or take any drugs or medications within twelve hours of the incident?_________ If yes, state the type and amount _______________
____

Employer ____

Employer's Address ___________________________________

Employer's Phone ___________________ Occupation ___________________

Supervisor ___________________ Average weekly wage ___________________

Are you still employed by this employer?___________________________

Work responsibilities____

Employer's Insurance Co. ___________________ Name of adjuster ___________

Insurance Co. Address _______________________________________

Insurance Co/Adjuster Telephone Number____________________________

Did you go to the hospital?_______ If so, where_________________________

Date admitted ___________________ Release Date___________________

Primary treating physician ___________________ Last seen by physician _________

Names of Doctors

Date Name of Doctor and address

________________ ______________________________________

________________ ______________________________________

________________ ______________________________________

________________ ______________________________________

Have you had surgery due to incident?________ If Yes, when and where___________

____

What type of surgery?_______________________________________

Date able to resume employment _______________________________

Current medications ____

MMI date ___________________ Restrictions ___________________

Have you been treated by a psychologist/psychiatrist?_______If so, when, where, what for?____

Have you been treated for Drug/Alcohol problems?______If so when, where, what for?

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