

# CLAIMS INFORMATION FORM

## CLAIM INFORMATION - Please type or print clearly

1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_
9. Insurance Carrier(s): \_\_\_\_\_
10. Other Defendants: \_\_\_\_\_
11. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed  
Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)
12. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. Defense Counsel: \_\_\_\_\_
16. Plaintiff's Counsel: \_\_\_\_\_

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_