All Forms (/form_templates) Form templates

Personal Injury (Med Mal)

Edit Form (/form_templates/543740/edit)

Waldron/Tate/Land

Waldron Tate Bowen Land LLC
156 E. Market St., 5th Floor
Indianapolis, IN 46204

On behalf of Waldron Tate Bowen Land LLC, (“Firm”), thank you for giving us the opportunity to represent you. Our Firm is committed to providing top quality legal representation and services customized to each client’s needs. Please read the privacy policy below, and then fill out this form in its entirety.

Privacy Policy
All information received from a client is strictly confidential. Our firm takes every step possible to protect your privacy. The data submitted via this form is encrypted and secured using industry-standard 256-bit SSL encryption.

Your Social Security number and other personal information will only be used only when necessary in limited use during the course of your case.

Social Security numbers are most often used to positively identify parties. Most courts require Social Security numbers of all parties in a case. Some other examples of how this information may be used include:

- initial service
- in court orders
- in required reports or other documents filed with the State
- to gather medical and employment records

If you have any questions, please don't hesitate to contact our law office. We look forward to working with you!

Contact information: Name and Address

Prefix

First name *

Middle name

Last name *

Date of birth

MM/DD/YYYY

Email (required when in public form)

Phone number

Street address

City

State/Province

Zip/Postal code

Social Security Number:

Please enter your response

Does anyone else live with you at your current address?

- ◯ Yes
- ◯ No

All Addresses for last 10 years:

Please enter your response

Are you married?

- ◯ Yes
- ◯ No

Are you divorced?

- ◯ Yes
- ◯ No

Do you have children?

- ◯ Yes
- ◯ No

Have you ever gone by any other names? (e.g., maiden name)

- ◯ Yes
- ◯ No

Secondary Contact Name (Optional):

Please enter your response

Secondary Contact Phone Number (Optional):

Please enter your response

Driver's License State and Number:

Please enter your response

Have you ever filed for bankruptcy?

- ◯ Yes
- ◯ No

Medical Malpractice Information

Date of Treatment at Issue

City of Treatment at Issue

Please enter your response

Location of Treatment at Issue

Please enter your response

Describe in your own words the treatment at issue:

Please enter your response

Names of any known medical personnel involved:

Please enter your response

Witness Information

Did anyone else witness the care provided?

Witness 1

- ◯ Fill out witness information
- ◯ Not applicable

Witness 2

- ◯ Fill out witness information
- ◯ Not applicable

Witness 3

- ◯ Fill out witness information
- ◯ Not applicable

Witness 4

- ◯ Fill out witness information
- ◯ Not applicable

Names of friends/family/colleagues who can testify as to your condition pre/post incident and/or saw you through recovery:

Please enter your response

Injuries

Please describe any and all aches, complaints, discomforts and disabilities, as a result of the medical care provided, in detail.

Please enter your response

Check all symptoms you have noticed since the medical care provided:

☐**Headache**☐**Neck pain**☐**Hands cold**☐**Loss of balance**☐**Depression**☐**Pins & needles in arms or legs**
☐**Nervousness**☐**Numbness in toes**☐**Chest pain**☐**Neck stiffness**☐**Stomach upset**☐**Fainting**☐
Light sensitivity☐**Ears ringing**☐**Shortness of breath**☐**Bruising**☐**Dizziness**☐**Sleeping problems**☐
Back pain☐**Memory loss**☐**Fatigue**☐**Tension**☐**Muscle pain**

Did you have any x-rays or other imaging performed?

- ◯ Yes

- ◯ No

Have you seen another doctor since the date of the treatment at issue?

- ◯ Yes
- ◯ No

Injury History

Have you had any accidents or injuries before this collision?

Injury #1:

- ◯ Fill out injury information
- ◯ Not Applicable

Injury #2:

- ◯ Fill out injury information
- ◯ Not Applicable

Injury #3:

- ◯ Fill out injury information
- ◯ Not Applicable

Injury #4:

- ◯ Fill out injury information
- ◯ Not Applicable

Additional Past Injury Information:

Please enter your response

Are you currently on any medications?

- ◯ Yes
- ◯ No

Medical Provider History

Please provide a list of all medical providers you have seen for the last 5 years. This includes chiropractors, pharmacies, primary care providers, hospitals, specialists, etc.

Name and Address of all medical providers for the last 5 years:

Please enter your response

Do you have any serious or chronic medical conditions?

Please enter your response

Do you have any signficant past medical history such as prior surgeries or hospitalizations? If yes, please give a description and location and approximate dates of treatment.

Please enter your response

Loss of Earnings

If you anticipate loss of earnings due to accident related injuries, please complete the following:

Were you working at the time of the collision?

- ◯ Yes
- ◯ No

Did you miss work as a result of your injuries?

Please enter your response

If yes, how much work did you miss?

Please enter your response

Amount of money lost as a result of missed work:

Please enter your response

Additional Information:

Any additional information you think would be helpful?

Please enter your response

Document Request

Please upload or email any documents that would be helpful such as:

Medical Records
Medical Bills
Insurance Correspondence
Accident Report
Police Report
Photographs
Front and Back of Driver's License
Calendar, diary, or notes related to the medical care provided

Would you like to attach the above documents now?

- ◯ Yes
- ◯ I will send them at a later time

THANK YOU

Thank you so much for completing this intake questionnaire. This information will be extremely helpful in moving forward with your case. We will contact you soon to discuss any further questions related to your answers.

Please click the **SUBMIT** button below when you have finished answering all questions.
This is a form preview