

BURNETTI, P.A.

Client Questionnaire

1. Please list the following:

Full Legal Name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

2. Were you married at the time of the incident? ☐ Yes ☐ No

Spouses Name: _____

3. At the time of the incident, were you suffering from any medical or physical infirmity, disability or sickness? If so, please list the nature of each.

4. Were you employed at the time of the incident? ☐ Yes ☐ No
If so, please provide the following:

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

5. Have you lost any income due to this incident? ☐ Yes ☐ No

If so, how much? \$_____ # of Days Missed: _____

Please provide my office with Check stubs, doctor notes for missing work, etc.

6. If you have lost income, please list your employment history for the last 3 years, including estimated dates of employment, rates of pay, and position.

7. Other than medical bills and/or loss of income, do you have any other bills related to this incident? (i.e. vehicle repair bill, prescription purchases, help with housework, etc.)

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8. Did you have health insurance at the time of the incident? ☐ Yes ☐ No
Health Insurance Provider: _____ Claim #: _____
Have they paid any of your medical bills related to this incident only? ☐ Yes ☐ No
9. Did you at the time of the incident have Medicaid and/or Medicare? ☐ Yes ☐ No
Do you currently have Medicaid and/or Medicare? ☐ Yes ☐ No
If so, please provide us with the name of the Medicaid/Medicare Provider (i.e. Amerigroup, Medipass, etc.) and your ID number.

10. Please list all physicians that have treated you for your injuries related to this incident.

11. Have you made a claim for injuries in the last 5 years? ☐ Yes ☐ No
If so, please indicate the injuries and the date(s) the injuries occurred.

12. Do you know of any witnesses that you have not already provided my office with that would have knowledge of the incident and/or your injuries? If so, please list their names and contact information.

13. Did you consume any alcoholic beverages or take any drugs (including prescribed medications) in the 12 hours before the incident? ☐ Yes ☐ No
If so, please list each alcoholic beverage, drug or medication and when and where you consumed each.

14. Did the at fault party make any kind of statement or remark to you before or after the incident?

15. Do you have any photographs of your injuries and/or the vehicle that was involved in the incident that have not already been provided to my office? ☐ Yes ☐ No

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Documents needed at this time:

1. If you have ***not*** already provided a copy of your Health Insurance Card, please include one with this questionnaire.
2. If you have ***not*** already provided them to our office, please include color copies of any photographs of your injuries, the scene of the incident and/or any property damage involved in the incident.