

BASSO AND ASSOCIATES

ATTORNEYS AT LAW

MEDICAL MALPRACTICE CASE INFORMATION QUESTIONNAIRE

- PAGE 1 OF 5 -

Please complete this form as accurately as possible and mail or fax to:

BASSO AND ASSOCIATES, PC

1171 ROUTE 55
LAGRANGEVILLE, NY 12540
FAX: 845-452-0261

Please print or type

DATE _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ MARITAL STATUS _____

SOCIAL SECURITY NUMBER _____

REFERRAL SOURCE (please check one) TV COMMERCIAL TV SHOW YELLOW PAGES FRIEND

OTHER (please explain) _____

LIST ANY PREVIOUS LAWSUITS OR CLAIMS, INCLUDING WORKER'S COMPENSATION.
PLEASE INCLUDE DATES, NAMES OF ATTORNEYS, INJURIES AND TYPE OF CASE.

EMPLOYER'S NAME AND ADDRESS WITH DETAILS OF WORK (if retired, please note)

SALARY/EARNINGS PER HOUR _____

CURRENT STATUS (if disabled, please give date) _____

TOTAL AMOUNT OF LOST WAGES TO DATE _____

HAVE YOU APPLIED FOR SOCIAL SECURITY DISABILITY DUE TO YOUR MALPRACTICE CONDITION?
IF SO, WHAT IS THE STATUS OF THAT APPLICATION?

HAVE YOU RETURNED TO WORK? _____

WILL YOU BE ABLE TO RETURN TO WORK IN THE FUTURE? _____

ORANGE COUNTY LAW CENTER

263 Rt. 17K
NEWBURGH, NY 12550

DUTCHESS COUNTY LAW CENTER

1171 ROUTE 55
LAGRANGEVILLE, NY 12540

ULSTER COUNTY LAW CENTER

70 MAIDEN LANE
KINGSTON, NY 12401

1-877-BASSO-LAW

WWW.BASSOLAW.COM

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PLEASE EXPLAIN YOUR GENERAL HEALTH BEFORE MALPRACTICE

EXACT DATE YOU BELIEVE MALPRACTICE OCCURRED _____

EXPLAIN WHAT EXACT INJURIES YOU HAVE DUE DIRECTLY TO MALPRACTICE

NAME OF DOCTOR AND/OR MEDICAL GROUP _____

ADDRESS _____

CITY, STATE, ZIP _____

NAME OF HOSPITAL _____

ADDRESS _____

HAVE YOU DISCUSSED MALPRACTICE DIRECTLY WITH THE DOCTOR OR THE HOSPITAL?
(if yes, please give details)

HAVE YOU FILED A COMPLAINT WITH ANYONE? (DEPT. OF HEALTH OR HOSPITAL ADMINISTRATION?)
(if yes, please give details)

HAVE ANY DOCTOR(S) OR HEALTH PERSONNEL BEEN CRITICAL OF THE CARE YOU RECEIVED?
PLEASE GIVE DETAILS TO INCLUDE NAME OF PERSON AND WHAT THEY SAID

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DID ANY WITNESSES EVER HEAR YOUR CONVERSATIONS WITH DOCTORS, NURSES OR MEDICAL PERSONNEL REGARDING YOUR MEDICAL CARE, SUCH AS WHO WAS AT FAULT OR ANY SPECIFIC DETAILS? IF SO, PLEASE LIST NAMES OF WITNESSES AND THE SUBSTANCE OF WHAT THEY HEARD

HAVE YOU RECEIVED ANY TREATMENT TO CORRECT OR HELP YOU DEAL WITH YOUR INJURY FROM THE MALPRACTICE? IF SO, PLEASE GIVE SPECIFIC DETAILS

DO YOU HAVE COPIES OF YOUR MEDICAL RECORDS RELATING TO YOUR CARE? _____

WHAT DAILY PROBLEMS DO YOU HAVE TODAY DUE TO THE MALPRACTICE? _____

HAVE YOU LOST TIME AT WORK OR BEEN FORCED TO STOP WORKING? *(please explain)* _____

HAVE YOU CONSULTED WITH OTHER ATTORNEYS REGARDING THIS POSSIBLE CASE? IF SO, PLEASE LIST THEIR NAMES AND THE STATUS OF THAT CONSULT

DID YOU SIGN ANY PAPERWORK WITH ANY OTHER ATTORNEY? _____

HOW ARE YOU PAYING FOR MEDICAL CARE? _____

WHAT OUT-OF-POCKET EXPENSES HAVE YOU INCURRED? _____

HAVE YOU DONE ANY RESEARCH ON YOUR CONDITION? _____

WILL YOUR CURRENT PHYSICIAN HELP YOU WITH THIS POSSIBLE CASE BY CONFIRMING MALPRACTICE AND TESTIFY IN COURT ON YOUR BEHALF? YES NO

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PERTINENT INFORMATION THAT YOU FEEL IS IMPORTANT TO YOUR CASE *

* PLEASE COMPLETE TIME-LINE ON THE FOLLOWING PAGES

I agree that by submitting this form, I am giving my authorization to Basso and Associates, PC to discuss my case and the information provided with its consultants. I agree that this does not constitute a request for legal advice and that I am not forming an attorney/client relationship. I understand that I may only retain an attorney by signing a formal written retainer agreement.

This will confirm that Basso and Associates has **not** been retained as attorneys in this case. Further, Basso and Associates reserves the right to reject this case with no further obligation to contact me. I may consult with other attorneys at any time.

DATE _____

PRINT NAME _____

SIGNATURE _____

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NAME _____

ADDRESS _____

TIME-LINE

PLEASE INCLUDE NAMES, OFFICE VISITS, SURGERIES, CONVERSATIONS, ETC.
DUPLICATE THIS PAGE IF NECESSARY.

DATE _____ EVENT _____

DATE _____ EVENT _____

DATE _____ EVENT _____

DATE _____ EVENT _____

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SIGNATURE _____

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