THE Layon LAW FIRM

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INFORMATION FOR ALL INJURY CASES

Please bring this form with you to your initial office conference.

Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________

Work Phone: ______________ E-Mail: ______________

SSN: ______________ Drivers License #: ______________ DOB: __________

Date of Injury: ______________ Time of Injury: ______________ A.M. / P.M.

Do you have a Police Report? ______________ Taken by EMSA? ______________

Injury occurred in: County: ______________ City: ______________

General location of incident: ______________________________

Who is your Insurance Carrier? ______________ Policy # ______________

Address: ______________________________ Phone: ______________

Who is the Insurance Carrier for the liable party? ______________________________

How injury occurred: ______________________________

Body parts affected: ______________________________

Are you currently working? ______________________________

Have you missed work due to this incident? __________ If so, how many days? __________

How did the incident occur and exactly what were you doing at the time of your injuries: ______________________________

Any prior incidents/claims? ______________________________

What injuries did you sustain from your previous incident? ______________________________

INFORMATION ABOUT YOUR MEDICAL PROVIDERS

Provider Name: ____

Address: ____

City: ________________________ State:_______ Zip:______________

Dates Seen: ____

Reason for visit: ____

Provider Name: ____

Address: ____

City: ________________________ State:_______ Zip:______________

Dates Seen: ____

Reason for visit: ____

Provider Name: ____

Address: ____

City: ________________________ State:_______ Zip:______________

Dates Seen: ____

Reason for visit: ____

Provider Name: ____

Address: ____

City: ________________________ State:_______ Zip:______________

Dates Seen: ____

Reason for visit: ____

Fill out the following section only if your injury happened while on-the-job.

INFORMATION ABOUT YOUR ON-THE-JOB INJURY

Date of Injury: __________________ Time of Injury:___________ A.M. / P.M.

Was your employment agreement made in Oklahoma: ____________________________

How injury occurred: ____

Body parts affected: ____

What was the last day you worked after the incident? ____________________________

Have you returned to work? If so, what date: ___________________________________

Are you currently receiving workers compensation benefits?_______________________

If so, how much? ____

Have you ever filed a workers' compensation claim before? ________________________

If so, please explain: ____

Is this injury an aggravation of a previous injury or condition: ______________________

Were there any witnesses? YES/NO If so, please list their names: _________________

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CONFIDENTIALITY NOTICE

The information herein provided to THE LAYON LAW FIRM is submitted for the purpose of facilitating the rendition of professional legal services. The above information is protected from disclosure pursuant to the provisions of *Okla. Stat. tit.* 12, 2502 (2002) and Rule 1.6 of the Rules of Professional Conduct as adopted by the Supreme Court of the State of Oklahoma.