Hoffman, Wachtell & Rao, LLP

Claimant Information

Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

_____ Telephone: _____

_____ Cell: _____

Employer Information

Name: _____ Concurrent: ☐ Yes ☐ No

Address _____ Job Title: _____

_____ Average Weekly Wage: _____

_____ Years Employed: _____

Accident Information

Date of Accident: _____ Circumstances of Injury/Incident:

Time of Accident: _____ _____

Prior Accidents/Illnesses to any body part: _____

_____ _____

_____ _____

_____ _____

Witnesses: _____ Injuries Sustained: _____

_____

Case Information

Person that you notified about the accident: _____ ☐ In Writing ☐ Orally

Date Notified: _____ Carrier Name: _____

How long did you work at this employer? _____ Carrier Case No.: _____

Receiving Disability? ☐ Yes ☐ No Lost time: _____

Third Party? ☐ Yes ☐ No _____

Retired? ☐ Yes ☐ No Nature and Amount of Payment: _____

Attorney: _____

Please Sign Here: _____ ***Date:*** _____

Doctor Information

Name: _____

Address: _____

_____

Dates of Treatment: _____

_____

Hospital Information

Name: _____

Address: _____

_____

Dates of Surgery: _____

_____

Doctor Information

Name: _____

Address: _____

_____

Dates of Treatment: _____

_____

Hospital Information

Name: _____

Address: _____

_____

Dates of Surgery: _____

_____

Concerns of Claimant/Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I attest that the information given above in this Intake Form is true and correct.

Signature: _____ ***Date:*** _____

Referred by: _____