



SELECT MEDICAL SPECIALISTS

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PERSONAL INJURY INTAKE FORM

Attorney Name: _____ Phone: _____ Fax: _____

Date of Call: _____ Attorney Email: _____

Patient Name: _____ Phone: _____

Address: _____

Patient DOB: _____ Patient SSN: _____

Visit Type:

- Consult only for settlement
- Evaluation & Treatment - Limited
- Evaluation & Treatment - Surgery

Report Type:

- Formal Report
- Formal Report with record review
- Formal Report with verbal opinion and clinic note

Other Instructions: _____

Specific body parts for treatment: _____

_____ DOI (Date of Incident): _____

Accident Type: MVA Slip & Fall Dog Bite Other (describe): _____

Police at Scene?: YES NO Police Report Taken?: YES NO

Emergency Care provided?: YES NO

Where at (If so?): Hospital ER Primary Care Other (describe): _____

Are the patients medical records available? YES NO

Med-Pay? YES NO How much?: _____ Exhausted?: YES NO

Carrier? _____

Policy # or Claim #: _____ Policy Limits (If known): \$ _____

Uninsured Motorist Coverage?: YES NO If so, how much?: \$ _____

IF DOI IS OVER 30 DAYS:

Where has the patient had treatment so far?: _____

Are there diagnostic studies?: YES NO

If so, where: _____ What date?: _____

What body part was diagnosed?: _____

Signature (Attorney or Patient): _____

Today's Date: _____

Please fill out and **fax** to the number above or **scan and email** to mlopez@davidkupfermd.com