

LAW OFFICE OF STEPHEN H. OSBORNE

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Medical Malpractice: Client Intake

INJURED PERSON'S INFORMATION

NAME: _____ AGE: _____ DATE: _____

ADDRESS: _____

PHONE NUMBERS: (Home) _____ (Office) _____ (Cell) _____

E-MAIL: _____

Preferred Method of Contact: _____

MEDICAL NEGLIGENCE INFORMATION

What injuries were sustained: _____

Date of suspected negligence: _____

What do you claim a doctor/hospital/nurse did or did not do to cause an injury? _____

Who is the claim against: _____

What date were symptoms first noticed: _____

Did the injury require additional surgery:

Where: _____ Surgeon: _____ Date: _____

Any follow up treatment (dates and locations and treatment provided): _____

Current health status/treatment/permanency of injuries sustained: _____

In possession of medical records?: _____

Subsequent treating doctor's comments: _____

Did a treating doctor recommend any treatment that the injured declined? If so, what was recommended and why was it declined?

