CLAIMS INFORMATION FORM

CLAIM INFORMATION - Please type or print clearly

1. Name of Patient:______________________________ 2. Age:__________ 3. Sex:__________
4. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon):______________________________

____
5. Allegation(s) (as stated by patient/plaintiff):______________________________

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____
6. Date of Incident:__________ 7. Date Reported to Carrier:__________ 8. Location:__________
9. Insurance Carrier(s):______________________________
10. Other Defendants:______________________________
11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES ☐ NO ☐
12. Present Status: __________Incident Only __________Pending Suit __________Closed

    Date Closed:__________ Amount Paid:__________ Settlement or Judgment (circle one)
13. Condition and diagnosis at time of treatment:______________________________

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14. Dates and description of treatment rendered:______________________________

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____
15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT):______________________________

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16. Defense Counsel:______________________________
17. Plaintiff's Counsel:______________________________

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X**______________________________ Date:_____/_____/_____

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