

Date: _____

Referred By: _____



WRONGFUL DEATH QUESTIONNAIRE

It is important to complete this questionnaire as fully and accurately as possible. You will be paying for the time we spend on your case and you will save expenses by providing us with complete information. The information you provide on this form provides us with necessary information so that we can do our best work for you. Your thoroughness will alert us to items we should review. We do not know the facts of your case as well as you do. Tell us as much as you know.

Social Security Number Privacy Policy

Social Security information will only be used in the event you hire the firm to represent you in your legal matter, and then only when necessary, in limited use during the course of your case.

Signature

Date: _____

PROPOSED PERSONAL REPRESENTATIVE

Name:

First Last Maiden

Address:

Telephone: _____

Email: _____

DOB: _____

Social Security No. _____

Veteran _____ **Widow of Veteran?** _____

Status:

____ Never Married
____ Divorced: Date: _____
____ Widowed: Date: _____

Education/Training:

- High School
- GED
- Trade School
- College
- Graduate

Preferred Method of Contact:

_____ Mail _____ Email _____ Text

Have you ever been convicted of a felony? If yes, please explain:

Have you ever filed a petition for bankruptcy? If yes, please explain:

Chapter: _____ Date Filed: _____ Date Discharged: _____

PROPOSED CO-PERSONAL REPRESENTATIVE

Name:

First Last Maiden

Address:

Telephone: _____

Email: _____

DOB: _____

Social Security No. _____

Veteran _____ **Widow of Veteran?** _____

Status:

____ Never Married

____ Divorced: Date: _____

____ Widowed: Date: _____

Education/Training:

High School

GED

Trade School

College

Graduate

Preferred Method of Contact:

____ Mail _____ Email _____ Text

Have you ever been convicted of a felony? If yes, please explain:

Have you ever filed a petition for bankruptcy? If yes, please explain:

Chapter: _____ Date Filed: _____ Date Discharged: _____

DECEDENT

Full Name of Decedent: _____

Decedent's Address: _____

Decedent's County of Residence: _____

Decedent's Date of Birth: _____

Decedent's Social Security Number: _____

Decedent's Date of Death: _____

HEIRS

Heir	Name	Address	Age	Phone Number
Mother:				
Father:				
Spouse:				
Child:				
Child:				
Child:				
<i>List only brothers and/or sister if none of the above living.</i>				
Brother:				
Sister:				

INCIDENT DETAILS

Date of Incident: _____

Time of Incident: _____

Location of Incident:

Negligent Party: _____

Address: _____

Decedent's Car Insurance Company:

Phone Number: _____

Policy No.: _____

Driver's License No.: _____

Adjustor Contact Information:

Negligent Party Car Insurance Company:

Policy No.: _____

Adjustor Contact Information:

1. Description of Accident: Please be as specific and provide as much detail as possible.

2. Police Report No. _____

3. Was decedent transported by ambulance? If yes, please list agency's name and phone number:

4. Witness(es) – Names and Addresses:

5. Was the decedent employed at the time of the incident? Yes No

Name & Address of Employer:

Rate of Pay: _____

6. Was an autopsy performed? Yes No

If yes, where: _____

Does the Death Certificate state that the Autopsy report was available before cause of death was determined?

PLEASE PROVIDE COPIES OF ALL PHOTOS IN YOUR POSSESSION.

Were photos taken of the scene? By whom? _____

Were photos taken of the vehicles? By whom? _____

Were photos taken of you injuries? By whom? _____

Health Care Provider Information

Group Health Insurance Carrier: _____

Policy No.: _____

Insured: _____

Primary Care Provider's Name, Address and Phone Number:

List all physicians, hospitals, chiropractors, dentists and oral surgeons or any other medical provider that treated the decedent.

Name of Provider/Facility:

Treating Physician: _____

Complete Address:

Name of Provider/Facility:

Treating Physician: _____

Complete Address:

<p>_____</p> <p>Dates Treated: _____</p> <p>Description of Treatment:</p> <p>_____</p> <p>_____</p> <p>Bill paid? Yes No Unknown</p> <p>How much? _____</p>	<p>_____</p> <p>Dates Treated: _____</p> <p>Description of Treatment:</p> <p>_____</p> <p>_____</p> <p>Bill paid? Yes No Unknown</p> <p>How much? _____</p>
<p>Name of Provider/Facility:</p> <p>_____</p> <p>Treating Physician: _____</p> <p>Complete Address:</p> <p>_____</p> <p>_____</p> <p>Dates Treated: _____</p> <p>Description of Treatment:</p> <p>_____</p> <p>_____</p> <p>Bill paid? Yes No Unknown</p> <p>How much? _____</p>	<p>Name of Provider/Facility:</p> <p>_____</p> <p>Treating Physician: _____</p> <p>Complete Address:</p> <p>_____</p> <p>_____</p> <p>Dates Treated: _____</p> <p>Description of Treatment:</p> <p>_____</p> <p>_____</p> <p>Bill paid? Yes No Unknown</p> <p>How much? _____</p>

OFFICE USE ONLY

SOL: _____ File No. _____

Death Certificate Rec'd: Date: _____

CONTINGENCY FEE: _____ %
 Litigation Percentage _____ %
 Estate Fee: _____
 Hourly: _____