ATTORNEY-CLIENT WORK PRODUCT

Gill & Chamas, LLC.

Client Fact Sheet

NAME OF CLIENT:

HOME ADDRESS:

HOME PHONE NUMBER:

CELL PHONE NUMBER:

COUNTY:

DATE OF BIRTH:

SS#:

NAME OF SPOUSE:

EMPLOYERS NAME:

JOB TITLE:

EMPLOYER ADDRESS:

EMPLOYER PHONE NUMBER:

DATE OF ACCIDENT:

TIME OF ACCIDENT:

PLACE OF ACCIDENT:

TYPE OF INCIDENT (Please Circle One):

AUTOMOBILE *FALL-DOWN* *MEDICAL MALPRACTICE*

WORKERS COMPENSATION *OTHER:_____*

TYPE OF INJURIES:

HOSPITAL (Name, Address, Phone):

DOCTORS YOU HAVE TREATED WITH FOR THIS INCIDENT
(Name, Address, Phone, Approximate Dates of Treatment):

OTHER DOCTORS YOU HAVE TREATED WITH IN THE LAST 5 YEARS
(Name, Address, Phone, Approximate Dates of Treatment)

NOT FOR DISCOVERY