Submit Form to Turner & Sackett

Print

For Attorney Only: Statute of Limitations _____

TURNER & SACKETT LLC

Wrongful Death Intake Form

Please complete this intake form is as much detail as possible. It is very important that this information is as thorough and accurate as possible.

Information of Person Completing this Form:

Name: _____ _____

Relationship to Decedent:_____ _____

Address: _____ _____ _____

Home Phone Number: _____ _____ _____

Work Phone Number: _____ _____ **Okay to contact you at this number: Y ☐ N ☐**

Cell Phone Number: _____ _____ _____ **May we text you? Y ☐ N ☐**

Email Address: _____ _____ _ **Ok to email? Y ☐ N ☐**

Emergency Contact's Name and Phone Number:_____ _____ _____

_____ _____ _____ _____

How were you referred to our Office? _____ _____ ____

Proposed Personal Representative

Name: _____ _____

Relationship to Decedent: _____ _____ _____ _

Address: _____ _____ _____ _____

Phone Number: _____ _____

Social Security Number: _____ _____ _____

Date of Birth:_____ _____ _____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Have you ever filed a petition for bankruptcy: If yes:

Chapter: _____ ____ **Date Filed:** _____ _____

Date Discharged: _____ **County:** ____ _____

Proposed Co-Personal Representative

Name: _____ _____

Relationship to Decedent: _____ _____ _____ _

Address: _____ _____ _____

Phone Number: _____ _____

Social Security Number: _____ _____ _____

Date of Birth:_____ _____ _____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Have you ever filed a petition for bankruptcy: If yes:

Chapter: _____ ____ **Date Filed:** _____ _____

Date Discharged: _____ **County:** ____ _____

Decedent's Information

Name: _____ _____

Address: _____ _____ _____ **County:** ____ ____

Date of Birth: _____ _____

Social Security Number: _____ _____ _____ __

Married: _____ **Name of Spouse:** _____ _____ _____

Date, Time and Location of Occurrence: _____ _____ _____

_____ _____ _____ _____ ____

Weather Conditions at time of Occurrence: _____ _____ ____

Date of Death: _____ _____

Auto Insurance Company (if applicable): _____ _____ _____ _____

Auto Insurance Adjuster Information (if applicable):

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Health Insurance Information: _____ _____ _____ _____

Medicare/Medicaid? If yes, Card Number: _____ _____ _____

Medical History

*** PLEASE COMPLETE THE ATTACHED HEALTH CARE PROVIDER INFORMATION SHEET ***

Was Decedent Employed at time of Accident: Y ☐ N ☐ – If yes, please complete:
Name and Address of Employer:_____ _____ _____

_____ _____ _____ _____ _____

Rate of Pay: $ _____ _____

Any known lawsuits filed by Decedent: _____ _____ _____ _____

Did Decedent have property in Illinois or any other state? If yes, please identify the property and the location:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Did Decedent have a will: _____ _____ ____

List below the name, birthdate, age, address, and phone number of the following living relatives of the Decedent:

Father: _____ _____ _____ _____

_____ _____ _____ _____ _____

Mother: _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Spouse: _____ _____ _____ _____

_____ _____ _____ _____ _____

Children:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Brothers & Sisters

(List if none of the above are living)

Brothers' Names, Addresses and Phone Numbers:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Sisters' Names, Addresses and Phone Numbers:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Information about the Negligent/At-Fault Party

Name: _____ _____

Address: _____ _____ _____ _____

Phone Number: _____ _____

Social Security Number: _____ _____ _____

Driver's License Number: _____ _____

Description of Vehicle: _____ _____ _____ _____ _____

Insurance Information (if known): _____ _____ _____ _____

Claim Number: _____ _____

Adjuster's Name: _____ _____ Phone Number: _____ _____

Owner of Vehicle: _____ _____ _____

Owner's Address: _____ _____ _____ _____ _____

Facts of the Accident

Please give a brief description of what happened

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Did police respond to the accident: _____If yes, please list agency and case number:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

If so, do you know the disposition of the case? _____ _____ _____ ___

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

_____ _____ _____ _____
_____ _____ _____ _____ _____

Please list any witness (es):

Name: _____ _____ _____

Phone Number: _____ _____ _

Name: _____ _____ _____

Phone Number: _____ _____ _

Name: _____ _____ _____

Phone Number: _____ _____ _

Any photographs of the accident or accident's location? _____ _____ _

Additional information or comments:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Health Care Provider Information Sheet

*** ATTENTION ***

It is the client's responsibility to keep TURNER & SACKETT updated throughout the pendency of the case of any and all medical treatment and related medical bills associated with his/her claim. Any unknown medical bill(s)/liens/subrogations or any medical bill(s)/liens/subrogations provided after the conclusion of the case *WILL BE THE RESPONSIBILITY OF THE CLIENT.*

For Office Use Only:
DOA: _____
Injured Party: _____

Group Health Insurance Carrier: _____
Policy Number: _____
Insured: _____
Primary Care Provider's Name, Address and Phone Number_____
_____

Please complete the information listed below for all physicians, hospitals, chiropractors, dentists, and oral surgeons, or any other medical provider who has treated you due to this accident.

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ______________________ No: _______________________ Unknown: _______________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ______________________ No: _______________________ Unknown: _______________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ______________________ No: _______________________ Unknown: _______________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ______________________ No: _______________________ Unknown: _______________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ______________________ No: _______________________ Unknown: _______________________