GINSBERG LAW OFFICES, P.C.
LONG/SHORT TERM DISABILITY QUESTIONNAIRE

Personal Information

Your full name: _____SS#_____

Address: Street _____

City:_____State:_____Zip:_____

Home Phone_____ Pager_____ E-mail:_____

How did you learn about Ginsberg Law Offices?_____

If we had to reach you in an emergency, who should we call?

Emergency name _____ Phone #:_____

Birth date:_____ Age: _____

Case Information

What type of case do you have?

Short Term Disability (STD) _____ Long Term Disability (LTD) _____ Soc. Security _____

Who is your Employer? _____

Who is the Disability Insurance Carrier? _____

Name of Adjuster: _____

Policy Number: _____

Claim Number: _____

What was your occupation as of your date of disability? _____

Describe your regular job duties: _____

_____

_____

Date Claim Filed: _____

Date Claim Denied/Terminated: _____

MEDICAL CONDITIONS:

Please list your health problems which make you unable to work (list them in order of severity):

1. _____
2. _____
3. _____
4. _____

MEDICAL TREATMENT:

Are you presently under doctor's care: Yes_____ No _____

Is there one doctor who knows your case the best and would be willing to help us prove that you are unable to work? Which doctor?_____

Please list the doctors that have treated you:

Doctor's name				Specialty			
Address:				City		State/Zip	
First seen:		Last seen			Next appt.		
Describe treatment							

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Address:				City		State/Zip	
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Address:		City	State/Zip
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Doctor's name		Specialty	
Address:		City	State/Zip
First seen:	Last seen	Next appt.	
Describe treatment			

Doctor's name		Specialty	
Address:		City	State/Zip
First seen:	Last seen	Next appt.	
Describe treatment			

Hospitals

Please list all of the hospitals that have treated you for conditions related to your current disability:

Hospital name		Specialty			
Address:		City		State/Zip	
First seen:		Last seen		Next appt.	
Describe treatment (in patient/out patient/emergency room):					

Hospital name		Specialty			
Address:		City		State/Zip	
First seen:		Last seen		Next appt.	
Describe treatment (in patient/out patient/emergency room):					

Hospital name		Specialty			
Address:		City		State/Zip	
First seen:		Last seen		Next appt.	
Describe treatment (in patient/out patient/emergency room):					

Have you ever had surgery? If so, please provide date and description:

Type of surgery			
Date of surgery		Name of hospital:	
Surgeon:			
Was surgery successful:			

Type of surgery			
Date of surgery		Name of hospital:	
Surgeon:			
Was surgery successful:			

Type of surgery			
Date of surgery		Name of hospital:	
Surgeon:			
Was surgery successful:			

MEDICATIONS:
Please list all of the medications you are presently taking:

Name of Drug	Dosage	How often do you take?	What condition/why do you take?	Prescribing doctor

Please provide any additional information that you think may assist us with your case:

_____

_____

_____

_____

_____

_____

_____

Please attach a copy of your STD/LTD Policy Manual (if you do not have one, request one from your employer) and copies of any and all correspondence you may have received.