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 Gir	nsberg Law Offices?	
If we had to reach you in an	emergency, who should v	we call?
Emergency na	ime	Phone #:
Birth date:	Age:	
Case Information		
What type of case do you ha	ave?	
Short Term Disability (STD)	Long Term Disab	bility (LTD) Soc. Security
Who is your Employer?		
Who is the Disability Insurar	nce Carrier?	
Name of Adjuster:		
Policy Number:		
Claim Number:		
What was your occupation a	as of your date of disability	y?
Date Claim Filed:		
Date Claim Denied/Termina	ited:	

EDICAL TREA	TMENT:			
	/ under doctor's care: Yes	No		
	ole to work? Which doc			
it you are unat	ole to work? Which doc	tor?		
at you are unab		.tor? u:		
ease list the do	ole to work? Which doc	u: Specialty		
ease list the do	ole to work? Which doc	.tor? u:		State/Zip
	ole to work? Which doc	u: Specialty	Next	
ease list the do	ole to work? Which doc	u: Specialty		
ease list the do	ole to work? Which doc	u: Specialty	Next	
ease list the do	ole to work? Which doc	u: Specialty	Next	
ease list the do	ole to work? Which doc	u: Specialty City	Next	
ease list the do octor's me Idress: escribe treatment octor's me	ole to work? Which doc	u: Specialty City Specialty Specialty	Next	State/Zip
ease list the do octor's me Idress: escribe treatment	ole to work? Which doc	u: Specialty City	Next	

Doctor's name		Specialty			
Address:		City		State/Zip	
First seen:	Last seen		Next appt.		
Describe treatment		1	'	I	
Doctor's name		Specialty			
Address:		City	-1	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					
Doctor's name		Specialty			
Address:		City		State/Zip	
First seen:	Last seen		Next appt.		
Describe treatment					

<u>Hospitals</u>
Please list all of the hospitals that have treated you for conditions related to your current disability:

Address: City State/Zip First seen: Last seen Describe treatment (in patient/out patient/emergency room): Hospital and and and and another and appt. Describe treatment (in patient/out patient/emergency room): Hospital and another appt. Describe treatment (in patient/out patient/emergency room): Hospital appt. Describe treatment (in patient/out patient/emergency room): Hospital and appt. Describe treatment (in patient/out patient/emergency room): Hast seen: City State/Zip State/Zip First seen: City State/Zip 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:	Address: City State/Zip					
Describe treatment (in patient/out patient/emergency room): Hospital	Describe treatment (in patient/out patient/emergency room): Hospital name					
Hospital name Address: City State/Zip First seen: Last seen Describe treatment (in patient/out patient/emergency room): Hospital name Address: City Specialty Address: City State/Zip First seen: Last seen Next appt. Describe treatment (in patient/out patient/emergency room): 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 Name of hospital:	Hospital name Address: City State/Zip First seen: Last seen Next appt. Describe treatment (in patient/out patient/emergency room): Hospital name Address: City State/Zip First seen: Last seen Next appt. First seen: Last seen Next appt.					
Address: Last seen Next appt.	Address: City State/Zip First seen: Last seen Next appt. Describe treatment (in patient/out patient/emergency room): Hospital name Address: City State/Zip First seen: Last seen Next appt.					
Address: Last seen Next appt.	Address: City State/Zip First seen: Last seen Next appt. Describe treatment (in patient/out patient/emergency room): Hospital name Address: City State/Zip First seen: Last seen Next appt.					
Address: Last seen	Address: City State/Zip First seen: Last seen Next appt. Describe treatment (in patient/out patient/emergency room): Hospital name Address: City State/Zip First seen: Last seen Next appt.					
Describe treatment (in patient/out patient/emergency room): Hospital name Address: City State/Zip	Describe treatment (in patient/out patient/emergency room): Hospital Specialty Specialty Address: City State/Zip First seen: Last seen Next appt.					
Describe treatment (in patient/out patient/emergency room): Hospital name Specialty State/Zip	Describe treatment (in patient/out patient/emergency room): Hospital 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:	Address: City State/Zip First seen: Last seen Next appt.					
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:	Address: City State/Zip First seen: Last seen Next appt.					
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:	Address: City State/Zip First seen: Last seen Next appt.					
First seen: Last seen	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:	appt.					
Have you ever had surgery? If so, please provide date and description: Type of surgery Date of surgery Name of hospital:	Describe treatment (in patient/out patient/emergency room):					
Type of surgery Date of surgery Name of hospital:		Describe treatment (in patient/out patient/emergency room):				
Type of surgery Date of surgery Name of hospital:						
Type of surgery Date of surgery Name of hospital:						
Date of surgery Name of hospital:	Have you ever had surgery? If so, please provide date and description:					
	Type of surgery					
Surgeon:	Date of surgery Name of hospital:					
I .						
Was surgery successful:	Was surgery successful:	- 1				

Type of surgery			
Date of surgery		Name of hospital:	
Surgeon:			
Was surgery suc	cessful:		
Type of surgery			
Date of surgery		Name of hospital:	
Surgeon:			
Was surgery suc	cessful:		
	cessful:		

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.