GUINN LAW

JAMES T. GUINN, PC
Workers Compensation Claim
Client Information Sheet

PLEASE PRINT LEGIBLY IN PEN - ALL FIELDS MARKED WITH * ARE REQUIRED.
IF YOU HAVE ANY QUESTION OR NEED HELP, PLEASE ASK!

Date ______ / ______ / ______

CLIENT INFORMATION

Full Name * ____________________

Former/Maiden Name ____________________

Social Security # * ______ - ______ - ______ Date of Birth * ______ / ______ / ______

Mailing Addresss* ____________________

City* ____________ State* ____________ ZIP* ____________

Home Phone* ____________ Cell Phone* ____________

E-mail Address* ____________________

Is E-mail a reliable method of contact?* Yes ☐ No ☐

EMPLOYER INFORMATION

Current Employer * ____________________

Work Phone Number * ____________________

Employer at time of injury (if different than current employer) * ____________________

____

Employer Address * ____________________

____

Employer Phone * ____________________

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CLIENT INFORMATION

EMERGENCY CONTACT (SPOUSE, IF APPLICABLE) *

Name * ______________________ Relationship * ______________________

Phone * ______________________ Alt. Phone ______________________

OTHER EMERGENCY CONTACT (SOMEONE WHO DOES NOT LIVE WITH YOU) *

Name * ______________________ Relationship * ______________________

Phone * ______________________ Alt. Phone ______________________

HEALTH INSURANCE INFORMATION

Private Health Insurance Carrier * ______________________

ID # * ______________________ Group # * ______________________

Subscriber (If someone other than self) * ______________________

REFERRED BY

- ☐ Drive - by
- ☐ avvo.com
- ☐ Oregon State Bar
- ☐ guinnlawteam.com
- ☐ Billboard
- ☐ Yellow Pages - Clackamas
- ☐ Yellow Pages - Portland
- ☐ Medical Provider ______________________
- ☐ Attorney ______________________
- ☐ Friend / Other ______________________

PLEASE BE PREPARED TO PROVIDE YOUR DRIVERS' LICENSE AND HEALTH INSURANCE CARD TO THE RECEPTIONIST, IF YOU SHOULD RETAIN AN ATTORNEY AT THIS OFFICE.