

DOUGLAS, LEONARD & GARVEY, P.C.

NEW HAMPSHIRE MEDICAL MALPRACTICE CHECKLIST

I. GENERAL INFORMATION

Your Name _____ Date of Birth: _____

Address _____

Home Phone Number _____ Work Phone Number: _____

Marital Status: _____

E-Mail Address: _____

Your Social Security Number: _____

Current Employer: _____

Work Address: _____

Length of Time With Employer: _____

II. DESCRIPTION OF CONDITION REQUIRING THE MEDICAL TREATMENT

YOU RECEIVED: _____

III. DESCRIPTION OF MEDICAL TREATMENT YOU RECEIVED WHICH IS

THE BASIS OF YOUR COMPLAINT: _____

IV. DESCRIPTION OF WHAT YOU BELIEVE THE DOCTOR(S) DID WRONG?

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V. **YOUR TREATING DOCTORS FOR ILLNESS OR CONDITION:**

Name

Address

1. _____

Diagnosis: _____

Period or Dates of Visits or Treatments: _____

Name

Address

2. _____

Diagnosis: _____

Period or Dates of Visits or Treatments _____

Name

Address

3. _____

Diagnosis: _____

NEW HAMPSHIRE MEDICAL MALPRACTICE CHECKLIST

Period or Dates of Visits or Treatments _____

Name

Address

VI. **CURRENT MEDICAL CONDITION:** _____

VII. **CURRENT DISABILITIES, IF ANY:** _____

VIII. **COMPLETE MEDICAL HISTORY:**

In considering a claim, it is important that we have a complete medical history. This includes all operations, workers' compensation injuries, other injuries or medical problems that you have had in the past including the dates of such injuries or medical problems and the names of all doctors or health care providers who treated you.

NEW HAMPSHIRE MEDICAL MALPRACTICE CHECKLIST

IX. **MOTOR VEHICLE AND CRIMINAL HISTORY**

Please list all motor vehicle or criminal charges, arrests or convictions you have ever had. If none, say so: _____

Return to:

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