Tracy A. Cinocca, P.C.
CINOCCA LAW

WRONGFUL DEATH CLAIMANTS

POTENTIAL NEW CLIENT INTAKE WORKSHEET
SUBJECT TO WORK PRODUCT PRIVILEGE

INTAKE QUESTIONNAIRE – LONG FORM

Life for an injury victim often times becomes much more difficult after the injury. Not only does the victim suffer physically and mentally, but now the victim or a representative must typically deal with government agencies, doctors, insurance companies and possibly attorneys. Each will require the victim or a representative to provide them with documentation. If you are the person providing the documentation, filling in the form below will prepare you for most of the questions these individuals need answered. Please complete all information as thoroughly as possible and update it, as information may become available to you. Expect in Litigation to see these questions asked of you and more, in a variety of ways numerous times. This will prepare you and your attorney for your case in Court or in other negotiations.

Your Name: ____
Name of Decedent: ____
Your Relationship to Decedent: ______________________________________
Your Date of Birth: ____/____/____
Your Social Security No.: ______-____-_______
Your Address: ____
____
____

Length of Time there: ________________

Prior Address: _______________________________________, Time there: ________

Best method to reach you: ____
Best times to reach you: ____

Mobile Phone: (_____) ______-________
Home Phone: (_____) ______-________
Work Phone: (_____) ______-________
Best Confidential E-mail Address: ___________________________________
Other Email: ____

DATE OF ACCIDENT RESULTING IN DEATH: ___/___/___
Negligence has a two year statute of limitations from this date to file a claim of record or be forever barred. You are not a client until an engagement agreement is executed by both of us. You are responsible for meeting any filing deadlines at this time. Please initial here you understand this and at present you are responsible for the timely filing of your claim: ***INITIAL:*** **____________**

DATE OF ACTUAL DEATH: ___/____/_____

Do you have a Certified Copy of the Death Certificate? **YES/NO** (circle)
If not, can you order it or acquire it beginning today? **YES/NO** (circle)
LOCATION OF DEATH: ____
STATE: _____ COUNTY: ________ CITY: ______________

RESIDENCE OF DECEDENT AT TIME OF DEATH: ______________________________
STATE: _____ COUNTY: ________ CITY: ______________

LOCATION OF ACCIDENT: ______________ ________________________________
STATE: _____ COUNTY: ________ CITY: ______________

Are you: Married: ____ Single: ____ Divorced: ____ Number of children: ____
If married, spouse's name: ____

Do you have access to the mail of Decedent? **YES/NO** (circle) How can you acquire access to Decedent's mail?
____
____
____
____

Note: This may include mail or email or anywhere Decedent may have received formal mail, medical invoices, or other mail.

Do you have access to the electronic devices of Decedent? **YES/NO** (circle) What devices did Decedent use most? ____
____

How would we or you acquire access to those devices? ______________________________
____
____

How did Decedent's accident occur? ____
____
____
____
____

How did you find out how the accident occurred? ______________________________
____
____

What injuries were sustained by Decedent? __________________________________
____
____
____
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Check any & all body parts affected by the accident: □Head □ Neck □Ears □Eyes □Nose □Face □Hair □Mouth □Jaw □Teeth □Tongue □ Mouth □ Taste □ Throat □ Smell □ Hearing □ Sight □ Shoulders □ Back □Upper Back □ Lower Back □ Hands □ Arms □ Wrists □ Fingers □ Hands □ Chest □ Sternum □ Torso □ Hips □ Bottom □ Legs □ Elbows □ Knees □ Thighs □ Ankles □ Feet □ Toes □ Mental □ Calves □ Mental □ Other ____________ □ Other ____________ □ Other ____________ □ Other _____________ □ Other ______________________

How did these injuries occur? ____

____
____
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Check all that may apply:
□ Defective product
□ Recall
□ Auto Accident
□ Dog Bite
□ Boating or other water related accident: Describe: ____
□ Trucking Accident
□ Slip or trip and fall
□ Corporate Fault (negligent party was on the job, driving a commercial carrier, or a company was somehow at fault or contributed to causing death) Who? ________________________ How? ____________________

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□ Government Fault (negligent party was on the job, driving a government vehicle, or a governmental entity was somehow at fault or contributed to causing death) Which Government entity? _____________________________________ How? ______________________________________

____

□ Wrongful Death Claims 12 O.S. §1053-54: Check Expenses & damages incurred that follow.

____ Funeral Expenses Paid by ___________ Best Contact Number: ________________________
Address for the Payee of Funeral Expenses: _____________________
____
Email for Payee of Funeral Expenses: ____

____ Decedent's Mental Pain and Anguish: To be Distributed, to the surviving spouse and children, if any. Please list any, with phone number, address and email on the following pages or state if there are none. ____
If none, shall be distributed to "Next of Kin.: Please Identify all surviving parents and grandparents by name, phone number, email and address requested below.

____ Loss of Consortium & Grief: Describe with whom now living: ________________________

____ The pecuniary loss to the survivors with age, occupation, earning capacity, health habits, and probable duration of the decedent's life. Describe who relief on Decedent for help: __________
____
____

____ The grief and loss of companionship of the children and parents of the Decedent, which shall be distributed to them according to their grief and loss of companionship

____ Punitive or Exemplary Damages to punish Defendant for reckless or intentional conduct. Explain: ____
____

_____ Other Please Describe: ____
____
____
____

QUESTIONS CONCERNING WRONGFUL DEATH STATUTORY CLAIMS VS PROBATE OR OTHER ESTATE CLAIMS

Did Decedent leave a Will or Trust? If so, do you have a copy? Please explain and issues: ____
____

Has a personal representative been appointed? ____

Are you aware of any other claims pertaining to Decedent being filed? If so, please explain: ____
____

Are you aware of any probate actions being asserted at this time? If so, explain. ____
____

What was the value and character of Decedent's property and debts at the time of his death? ____
____
____

Please Identify, the Following Relatives, Known to You of the Decedent:
Spouse? YES/NO
Name: ______________________
Address: _____________________
City State ZIP: ________________
Email: _______________________
Phone: ______________________

Children? YES/NO
If Yes, How Many? _________ Of these, how many are minors? _________

Name: __________________
Address: ________________
City State ZIP: ____________
Email: __________________
Phone: __________________
DOB/Age: ______________

Name: ________________
Address: ______________
City State ZIP: ________
Email: ______ ________
Phone: ______________
DOB/Age:____________

Name: ___________________
Address: _________________
City State Zip: ____________
Email: ____________________
Phone: ____________________
DOB/Age:_________________

Please attach additional sheets, if necessary for the children.
NOTE: Step Children and Step Parents Should not Be Listed Above. Children includes all biological and adopted children, only.

PARENTS:
Father's Name: _______________
Address: _____________________
City State ZIP: ________________
Email: _______________________
Phone: ______________________

Mother's Name: ______________
Address: _____________________
City State ZIP: ________________
Email: _______________________
Phone: ______________________

MATERNAL GRANDPARENTS:

Name: ______________________ Name: ______________________
Address: _____________________ Address: _____________________
City State ZIP: ________________ City State ZIP: ________________
Email: _______________________ Email: _______________________
Phone: ______________________ Phone: ______________________

PATERNAL GRANDPARENTS:

Name: ______________________ Name: ______________________
Address: _____________________ Address: _____________________
City State ZIP: ________________ City State ZIP: ________________
Email: _______________________ Email: _______________________
Phone: ______________________ Phone: ______________________

Please identify any persons previously listed who are deceased and when they passed away.
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____
____

Are there any family relationship issues of which you are aware that could affect your claims? _______________
If so, please describe: ____
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____

LIABILITY

What would you like to know about how the accident occurred? ____
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Who do you think is liable for the accident? ______________________________________ Why: ____________
____

Name: __________________	Name: ________________	Name: ___________________
Address: _________________	Address: ______________	Address: __________________
City State ZIP: ____________	City State ZIP: _________	City State Zip: _____________
Email: ___________________	Email: ______ _________	Email: ____________________
Phone: ___________________	Phone: _______________	Phone: ____________________
DOB/Age: _______________	DOB/AGE:____________	DOB/AGE:_________________

Please attach additional sheets, if necessary.

What facts known to you support your opinion of why each of the persons or companies listed by you should be held be liable? ____
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____
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What facts unknown to you affecting liability would you like to know more about? ________________________
____
____
____
____

Was a vehicle, watercraft or other product involved in the accident? _____________________________________
Please explain: ____
____
____
WHERE IS IT NOW? ____
HOW CAN WE GET IT, IF NECESSARY, OR FIND OUT WHERE IT IS, IF YOU DO NOT KNOW?
____
____
____

Is there a product recall? ____

List the names, addresses, and phone numbers of any possible witnesses in your case, not already listed on the Accident Report, if you have provided that already.

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YOUR INJURIES AND DAMAGES RESULTING FROM THE WRONGFUL DEATH

Describe your injuries here: ____
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Who do you believe caused or is responsible for your injury, and why? ___________________________
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Describe your loss of consortium claim in a way you might describe in detail to a jury. Attach additional pages, if necessary: ____
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Describe your mental grief and suffering in a way you might tell a jury. Attach additional pages, if necessary:
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List all doctors and other health care providers who have treated your injuries, including their names, addresses, and telephone numbers. Include the dates of treatment and any pre-existing issues physical and mental issues related and how they were exacerbated. Describe your treatment by each and how it helped. Please identify physicians and their associated groups, hospitals, emergency rooms, ambulances, radiologists, laboratories, pharmacies, mental health care professionals, and any other type of licensed professional from whom you may have received related treatment.

Name: ______________________	Name: ______________________
Address: _____________________	Address: _____________________
City State ZIP: ________________	City State ZIP: ________________
Email: _______________________	Email: _______________________
Phone: ______________________	Phone: ______________________
Name: ______________________	Name: ______________________
Address: _____________________	Address: _____________________
City State ZIP: ________________	City State ZIP: ________________
Email: _______________________	Email: _______________________
Phone: ______________________	Phone: ______________________
Dates of Treatments: ___________	______________________________

Describe Treatments & Services:____
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Name: ______________________	Name: ______________________
Address: _____________________	Address: _____________________
City State ZIP: ________________	City State ZIP: ________________
Email: _______________________	Email: _______________________
Phone: ______________________	Phone: ______________________
Name: ______________________	Name: ______________________
Address: _____________________	Address: _____________________
City State ZIP: ________________	City State ZIP: ________________
Email: _______________________	Email: _______________________
Phone: ______________________	Phone: ______________________
Dates of Treatments: __________	______________________________

Describe Treatments & Services:____
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Do you have Medicaid or Medicare? **YES/NO** (circle)
If so, you must attach a copy front and back of your cards. They will likely require reimbursement for any out of pocket payments and must be notified of your claims pursued.

Do you have other health insurance used for your treatments? **YES/NO** (circle)
If so, you must attach a copy front and back. They will likely require reimbursement for any out of pocket payments and must be notified of your claims pursued.

Have you received any itemized or other billing statements? **YES/NO** (circle)
If you have them, please produce them. If you receive more in the mail and we represent you, you must send us copies. Initial here you understand this**: INITIAL: _____________**
If your matter involves a vehicle accident, do you or did Decedent or any other members of his household have automobile insurance: **YES/NO** (circle)
If so, please provide a copy of your insurance.

Do you have any other insurance policies in effect that may provide you with any coverage for the incident in question? **YES/NO** (circle)
If so, please explain. ____

____

List the names, addresses, and telephone numbers of all insurance companies that may be involved which you have not previously identified, if known: (including, as applicable, other people's automobile insurer, disability insurer, homeowner's insurer, etc.). ____
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Are you claiming any future medical or mental health bills related to your claims? _____: If so, please explain what that is and the likely cost. Show how you computed said cost. ___________________________________
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____
____

When was the last day of your treatment? ______________ If treatment is ongoing, what is your expected course of future treatment? ____
____
____

Have you lost income as a result of your injuries? Check: Yes ______ Amount $________ or No ______
Income before injury $__________ per ___________
Income after injury $__________ per ___________
Employer ____
Position ____
Employer's address ____
____
____

Employer's telephone number (_____) _______-_________
Are you currently working? Yes ___ No ___ Expect to return to work on ___/___/___
Will not return to work ____

Are you in pain? If so, describe. ____
____
____
____

Describe any other ways in which your life has changed as a result of your physical injuries. (For example, changes in your life due to physical injuries like you are no longer able to engage in athletic activities, your appearance has changed, you cannot care for your children, etc.) ___________________________________
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____
____

Describe any other ways in which your life has changed as a result of your mental injuries. (For example, changes in your life due to emotional trauma, loss of consortium, pain, grief that may affect your day to day major life activities like sleep, and how those changes have affected your life, your appearance has changed, you cannot care for your children, etc.) ____
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If married, has your spouse experienced any losses as a result of your injury? If so, please Describe: __________
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____

DECEDENT'S INJURIES AND DAMAGES

Under the Oklahoma wrongful death statute one element of damages is for the "mental pain and anguish" suffered by Decedent before he died. Any amount awarded for this shall be distributed to the wife and children, or if none, then the Next of Kin in the same proportion as the personal property of the Decedent. 12 O.S. §1053(B)(3).

How might you describe in detail Decedent's mental pain and anguish before he died to a jury? Even if the time was short, please explain: ____

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____
____
____
____

Did Decedent have Medicaid or Medicare? **YES/NO** (circle)
If so, you must attach a copy front and back of your cards, or explain what you may know:____

Did Decedent have other health insurance he may have used? **YES/NO** (circle)
If so, you must attach a copy front and back. If you do not have the information but know something about this, please explain: ____

____
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____

Another category of damages allowed under Oklahoma's wrongful death statute includes: "The pecuniary loss to the survivors based upon properly admissible evidence with regard thereto including, but not limited to, the age, occupation, earning capacity, health habits, and probable duration of the decedent's life, which must inure to the exclusive benefit of the surviving spouse and children, if any, or next of kin, and shall be distributed to them according to their pecuniary loss." 12 O.S. § 1053(B)(4). The following questions relate to this.

Please state the following for the Decedent at the time of his passing:
Name: ______________________________
Last Address: ______________________________
CITY, STATE ZIP: ______________________________
Cell Phone: ______________________________ Provider: ____________________

What age was Decedent at the time of death? ________________

Occupation: ________________________
Employer: ________________________
ADDRESS: ________________________
CITY STATE ZIP: ___________________
Was Decedent working at the time of the accident? **YES/NO** (circle) If so, please describe:
____
____
____
____

How much did he earn? ____

What was Decedent's educational background: ____
What degrees, special licenses, certificate or other training, did he have? ______________________________

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____

Did Decedent have any other special occupational skills or abilities? **YES/NO** (circle) If so, please explain: ___

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____

If Decedent was under 33 years of age, or enrolled in school, how was his academic performance and history?

____

____

____

____

Did Decedent have any future plans for additional education or other training? **YES/NO** (circle)
If so, please explain: ____

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Please describe Decedent's job history, including titles and rates of pay:___________________________

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Did Decedent have any diagnoses, habits, conditions, behaviors, disabilities or other conditions that would limit his earning potential or lifespan? **YES/NO** (circle) Please describe: _______________________________

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Please circle any of the following which Decedent may have had or done and explain:

□ On SSI □ Medicare □ Medicaid □ Bankruptcy □ Divorce □ Arrests □ Convictions □ Drug Use □ Alcohol Use □ Smoking □ Marijuana. Prescriptions - legal or illegal. □ Handicaps □ Disabilities □ Mental Issues □ Inability to Understand □ Criminal Behaviors □ Reckless Behavior □ Fighting □ Violence □ Poor Relationships □ History of Litigation/Claims □ Limitations on Normal Life Expectancy □ Long term illnesses or conditions □ Negative Issues a private investigator for the Defendant might find out? ____________________________

____

If Decedent had any of these issues, how might Decedent had improved himself had he lived longer? If you believe it was a permanent condition for which change was not foreseeable or unlikely, then please say so.

What positive health habits did Decedent have?

What negative health habits did Decedent have?

Please Describe Decedent's relationships with his parents, spouse and children, if any:

Describe your pecuniary loss you believe you suffered as a result of Decedent's passing?

Describe your past relationship with Decedent and how that affects your current and future grief and loss of companionship claims? Attach additional pages, if necessary:

List all doctors and other health care providers who treated Decedent's injuries, including their names, addresses, and telephone numbers. Include the dates of treatment and any pre-existing issues physical and mental issues related and how they were exacerbated. Please identify physicians and their associated groups, hospitals, emergency rooms, ambulances, radiologists, laboratories, pharmacies, mental health care professionals, and any other type of licensed professional from whom you may have received related treatment.

Name: ______________________ Name: ______________________
Address: ____________________ Address: ____________________
City State ZIP: _______________ City State ZIP: _______________
Email: _______________________ Email: _______________________
Phone: ______________________ Phone: ______________________
Name: ______________________ Name: ______________________
Address: ____________________ Address: ____________________
City State ZIP: _______________ City State ZIP: _______________
Email: _______________________ Email: _______________________
Phone: ______________________ Phone: ______________________
Dates of Treatments: __________ _____________________________
Describe your treatment by each and how it helped. ____
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Which area of your body did each of the above providers treat? ____________________/____________________
Describe any preexisting conditions to those areas: ____
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____

Name: ______________________ Name: ______________________
Address: ____________________ Address: ____________________
City State ZIP: _______________ City State ZIP: _______________
Email: _______________________ Email: _______________________
Phone: ______________________ Phone: ______________________
Name: ______________________ Name: ______________________
Address: ____________________ Address: ____________________
City State ZIP: _______________ City State ZIP: _______________
Email: _______________________ Email: _______________________
Phone: ______________________ Phone: ______________________
Dates of Treatments: __________ _____________________________
Describe your treatment by each and how it helped. ____
____
____
____
____

Which area of your body did each of the above providers treat? ____________________/_____________________
Describe any preexisting conditions to those areas: ____

Name: ______________________	Name: ______________________
Address: ____________________	Address: ____________________
City State ZIP: ______________	City State ZIP: ______________
Email: _______________________	Email: _______________________
Phone: ______________________	Phone: ______________________
Name: ______________________	Name: ______________________
Address: ____________________	Address: ____________________
City State ZIP: ______________	City State ZIP: ______________
Email: _______________________	Email: _______________________
Phone: ______________________	Phone: ______________________
Dates of Treatments: __________	____________________________

Describe your treatment by each and how it helped. ____

Which area of your body did each of the above providers treat? ____________________/_____________________
Describe any preexisting conditions to those areas: ____

Attach additional pages as needed for more health care providers.

Did Decedent have Medicaid or Medicare? **YES/NO** (circle)
If so, you must attach a copy front and back of your cards or state you do not know or do not have it.

Did Decedent have other health insurance used for treatments? **YES/NO** (circle)
If so, you must attach a copy front and back or state you do not know or do not have it.

Have you received any itemized or other billing statements for Decedent? **YES/NO** (circle)
If you have them, please produce them. If you receive more in the mail and we represent you, you must send us copies. **Initial here you understand this: ____________**

If your matter involves a vehicle accident, did Decedent have automobile insurance: **YES/NO** (circle)
If so, please provide a copy of that insurance or state you do not know or do not have it.

Did Decedent have any other insurance policies in effect that may provide you with any coverage for the incident in question? **YES/NO** (circle)
If so, please explain. ____
____

List the names, addresses, and telephone numbers of all insurance companies that may be involved which you have not previously identified, if known: (including, as applicable, other people's automobile insurer, disability insurer, homeowner's insurer, etc.). ____
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Has income of Decedent has been lost? Check: Yes ____ Amount $_________ Or No _____
Income before injury $__________ per ___________
Income after injury $__________ per ___________
Employer ____
Position ____
Employer's address ____
____
____
Employer's telephone number (_____) _______-_________
Was Decedent working at the time of his death? **YES/NO** (circle)

Was Decedent in pain or did he suffer? **YES/NO** (circle) If so, describe. ______________________________
____
____
____
____

Describe any other ways in which your life has changed as a result of Decedent's death. (For example, changes in your life due to physical injuries like you are no longer able to engage in athletic activities, your appearance has changed, you cannot care for your children, etc.) ____
____
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Describe any other ways in which your life has changed as a result of your mental injuries. (For example, changes in your life due to emotional trauma, loss of consortium, pain, grief that may affect your day-to-day major life activities like sleep, and how those changes have affected your life, your appearance has changed, you cannot care for your children, etc.) ____

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MISCELLANEOUS

Have you previously consulted an attorney regarding your case? **YES/NO** (circle)

If yes, provide the attorney's name(s), the firm name(s), the address(es), and the telephone number(s). ____

Is your relationship with the attorney ongoing? **YES/NO** (circle)

Has an attorney declined to represent you in this matter? **YES/NO** (circle) If yes, why? ____________________

Do any prior attorneys have liens in your case? ____________________

If so, please describe and Identify the attorney with said lien: ____________________

Can you request and obtain a lien release and attach it hereto? **YES/NO** (circle)

Please explain the status if you are unable to attach a letter from that firm releasing any lien it has. __________

Please explain any limitations or disabilities or other conditions you have that could affect your ability to understand, travel to Oklahoma for depositions or trial, acquire notarized verifications and forms, respond promptly to emails or texts, scan, acquire documentation, transmit documents via text, email or mail, provide detailed descriptions and explanations, or perform other duties a client would have? ____________________

Can you overcome any limitations? **YES/NO** (circle)

How might you overcome these difficulties? ____________________

Are you willing to commit to do this? **YES/NO** (circle)

What do you hope to find out as a result of our services? ____________________

What compensation do you hope to receive as a result of our services? ____________________

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Is there anything else you would like for us to know or be aware? ________________________________
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Questions you have about your case: ____
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By signing this form, you acknowledge as of the date signed, you have provided all information known to you and agree to update the information provided as it becomes available. You understand that this does not create an attorney client relationship, and that such relationship is only created after the execution by both parties of an Engagement Agreement. By signing this agreement, you acknowledge and understand that said attorney has not agreed to file your case, and that you and you alone are responsible for meeting any and all deadlines on your case for filing or you may forever barred therefrom. If you have retained prior attorney(s) on this case, you need to acquire a waiver of any lien interest they may have or a statement of that lien amount from them for our review and consideration before we take your case.

AGREED BY:

X______________________________________
NAME:______________________________
Address: _____________________________
City State Zip: _________________________
Email: _________________________________
DOB: __________________________________
SSN: ___________________________________
DL NO.: __________________ State: ______ Exp: _____

RETURN YOUR COMPLETED FORM TO:
Tcinocca@cinoccalaw.com with Your name in the Re Clause and the words "PNC Personal Injury"

You may also mail your completed form to us at:
Tracy A. Cinocca, P.C.
10026A S. Mingo Rd, #238
Tulsa, OK 74133

If you would like a free consultation, please state the time and method that would serve you best: ___________
____
____
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