FEINBERG MED-LEGAL

STEVEN FEINBERG, M.D.

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You have requested a(n) medical legal _____ AME/Panel QME/D-QME/A-QME/RE-EVALUATION for the patient below. Please fill in all the information requested and fax this form back to our office. Appointment information will be faxed to all concerned offices. Please indicate clearly above if the appointment requested is a re-evaluation.

PATIENT INFORMATION:

Name: _____ **Mr. Ms.** (Circle One)

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: ( ) _____ **Cell Phone #** ( ) _____

(A valid phone number is needed before scheduling as a medical history is taken via phone with the patient one week prior to the appointment)

SSN#: _____ **WCAB #** _____ **DOB** _____

Area Injured: _____ **Claim #** _____ **DOI:** _____

INSURANCE INFORMATION: **EMPLOYER:** _____

Adj. Name: _____ **Mr. Ms.** (Circle One)

Insurance Co: _____

Address: _____ **Suite #** _____

City: _____ **State:** _____ **Zip:** _____

Phone #: ( ) _____ **Ext:** _____ **Fax:** ( ) _____

E-Mail Address: _____

Interpreter Needed: Yes No Language _____ (Interpreting services are NOT arranged by our office)
Circle One

Applicant Attorney		**Defense Attorney**	
Name:		**Name:**	
Firm:		**Firm:**	
Address:		**Address**	
City:		**City:**	
State:	**Zip:**	**State:**	**Zip:**
Phone:	( )	**Phone:**	( )
Fax:	( )	**Fax:**	( )
E-Mail Address:		**E-Mail Address:**	

Inches of Records to be Sent:

Name of Person Requesting Appt: **From: Def. Attny App. Attny Ins. Co.**

*****INCOMPLETE FORMS WILL NOT BE PROCESSED*****