HIP IMPLANT QUESTIONNAIRE

To speed our evaluation of your injury, please provide as much information as possible.
If you need more space to answer a question, please use extra paper (remember to number your answers).

BOX 1: INJURED PERSON'S INFORMATION

1.a. INJURED PERSON'S FULL NAME: _____ **DOB:** _____ **SSN:** _____

1.b. Injured Person's Address (include street address for PO Boxes):
_____
_____
_____
_____
COUNTY:

1. c. Injured Person's Telephone Numbers:
Home (___) ___-_____ Cell (___) ___-_____
Work (___) ___-_____ Fax (___) ___-_____
E-mail: _____

1.d. Spouse's Name (If Applicable): First:_____ Last: _____

1.e. Telephone numbers of 3 people or places of business which will always know the Injured Person's whereabouts:
1. Name _____ Relationship _____ Phone #1 (___) ___-_____ Phone #2 (___) ___-_____
2. Name _____ Relationship _____ Phone #1 (___) ___-_____ Phone #2 (___) ___-_____
3. Name _____ Relationship _____ Phone #1 (___) ___-_____ Phone #2 (___) ___-_____

1.f. Are you completing this form for Yourself or Someone Else? ❑ Myself *(skip to Box 3, below)* ❑ Someone Else *(go to Box 2)*

BOX 2: PERSON COMPLETING THIS FORM

2.a. Is the person completing this form the Injured Person?
❑ Yes *(If Yes, skip to Box 3, below)*
❑ No, I am completing this form on the Injured Person's behalf
If so, your name:

2.b. If you are completing this form on the Injured Person's behalf, what is your relationship to the Injured Person?
The Injured person is my: _____

2.c. If you are completing this form for the Injured Person, your Address (include street address for PO Boxes):
_____
_____
_____

2.d. If you are completing this form for the Injured Person:
Your Telephone: Home (___) ___-_____
Work (___) ___-_____
Mobile (___) ___-_____
Fax (___) ___-_____
Your E-mail:

2.e. Is the Injured Person: ❑ A Minor ❑ **Deceased - if Deceased – Date of death:** _____ ❑ Hospitalized ❑ Ill
❑ Other: _____

If person is deceased - we need a copy of the death certificate. And, has an estate been opened: _____ Yes _____ No
If an estate has been opened, we need a copy of any documents you have.

BOX 3: HIP IMPLANT INFORMATION - PLEASE COMPLETE IN AS MUCH DETAIL AS POSSIBLE:

What is the date of the first TOTAL HIP IMPLANT (we need a month and a year if possible) :_____ Which Hip was this : _____ Left _____ Right
Have you had another hip surgery to this same hip since then (REVISION SURGERY): ___ Yes ____ No. If yes, please give us the date for this surgery: _____ IF NO - HAVE YOU BEEN TOLD IT WILL NEED TO BE REPLACED : _____ Yes _____ No - If Yes - date for replacement: _____
If you have had other revision surgeries to the same hip, please list the dates :_____

Have you had a TOTAL HIP IMPLANT on your other hip: _____ Yes _____ No If Yes, date: _____
Which hip:_____ Left _____ Right
Have you had another hip surgery to this same hip since then (REVISION SURGERY): ___ Yes ____ No. If yes, please give us the date for this surgery: _____
If you have had other revision surgeries to the same hip, please list the dates :_____

BOX 4: RECALL INFORMATION

Have you received any recall notification from the manufacturer, Physician or facility: ____ Yes ____ No
If yes - what manufacturer: _____ (PLEASE INCLUDE A COPY)

Do you have any implant cards for any of your total hip implants: _____ Yes ____ No (If yes, please enclose)
Has any Physician told you what brand / model hip implant you have - if so, please list: _____

BOX 5: INSURANCE / PROVIDER INFORMATION

NAME OF PROVIDER THAT PAYED FOR EACH TOTAL HIP IMPLANT DEVICE: _____
(i.e. - Medicare, Medicaid, Blue Cross, Self Pay)

HAVE YOU HAD TO PAY BACK ANY FUNDS THAT YOU RECEIVED TO PAY FOR YOUR DEVICE:
____ Yes ____ No. If Yes, explain: _____

BOX 6: HIP SURGERY INFORMATION

FIRST HIP SURGERY DATE: _____ SIDE: _____ LEFT _____ RIGHT
PHYSICIAN NAME THAT PERFORMED SURGERY: _____
ADDRESS OF PHYSICIAN:_____
TELEPHONE NUMBER OF PHYSICIAN:_____
HOSPITAL WHERE IMPLANTED:_____
ADDRESS OF HOSPITAL:_____

SECOND HIP SURGERY DATE (IF APPLICABLE): _____ SIDE: _____ LEFT _____ RIGHT
PHYSICIAN NAME THAT PERFORMED SURGERY:_____
ADDRESS OF PHYSICIAN : _____
TELEPHONE NUMBER OF PHYSICIAN:_____
HOSPITAL WHERE REMOVED:_____
ADDRESS OF HOSPITAL:_____

THIRD HIP SURGERY DATE (IF APPLICABLE): _____ SIDE: _____ LEFT _____ RIGHT
PHYSICIAN NAME THAT PERFORMED SURGERY:_____
ADDRESS OF PHYSICIAN : _____
TELEPHONE NUMBER OF PHYSICIAN:_____
HOSPITAL WHERE REMOVED:_____
ADDRESS OF HOSPITAL:_____

BOX 7: ADDITIONAL INFORMATION

Are you now, or have you ever been represented by an attorney for your potential hip claim? ❑ Yes ❑ No
If yes, attorney's name: Law Firm:

Is there anything we did not ask that you think we should know? ❑ Yes ❑ No
If Yes, what