Client Information Sheet/Personal Injury Claims

Date: _____

Date of accident: _____ Time: _____ a.m. or p.m.

Location of accident (including county): _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____ Other Phone #: _____

Emergency Contact Information:

Name	Relationship	Address	Phone Number

Name	Relationship	Address	Phone Number

Employer: _____
Supervisor: _____
Address: _____ Zip Code: _____
Occupation: _____ Length of Employment: _____

Employer #2: _____
Supervisor: _____
Address: _____ Zip Code: _____
Occupation: _____ Length of Employment: _____

Social Security Number: _____ DOB: _____

Married: Yes or No Spouse's Name: _____

Spouse's Employer: _____
Supervisor: _____
Address: _____ Zip Code: _____
Occupation: _____ Length of Employment: _____
Spouse's Work Telephone Number: _____

Spouse's Social Security Number: _____ DOB: _____
Lost Wages: _____
Hourly: _____ Salary: _____
Spouse's Lost Wages: _____ Hourly: _____ Salary: _____

Impact of Collision: ___ Light Moderate Severe

Were Seatbelts Utilized: ☐Yes ☐ No

If you have the accident report, does it look correct? If not, please explain: _____

_____

_____

_____

Did any part of your body strike the vehicle? If so, please explain: _____

_____

_____

_____

Passengers: _____

Nature of Injuries: _____

_____

_____

_____

_____

_____

Were you transported by an ambulance? If so, by whom: _____

Medical Facilities/Treating Physicians: _____

_____

_____

_____

Has anyone taken photographs of you, the vehicle or the scene: _____

Who took the photos: (Name address and phone) _____

Witness List:_____

_____

_____

_____

Property Damage: _____

_____

_____

_____

_____

Who is the owner of the vehicle? _____

Where is the vehicle? _____

Who is the lien holder? _____

How much is the payoff? _____

Do you have estimates? If so, please list the amount (s): _____

Model: _____ Make: _____ Year: _____

Mileage: _____ Approximate Value of Vehicle: $_____

☐ ☐ ☐ ☐

Rental Car: Yes No Paid for by: Credit Card Insurance Company (name) _____

Prior Accidents including work related: _____

_____

_____

_____

_____

Pre-existing Medical Conditions: _____

_____

_____

_____

_____

Opposing Party: Name: _____ Telephone Number:_____

Address: _____

Opposing Party's Insurance Company: Name: _____

Adjuster: _____ Address: _____

Telephone Number: _____ Claim Number: _____

Limits: _____ Type of Case: _____

File Number: _____ Date of Loss: _____

Your Insurance Company: Name: _____

Adjuster: _____ Address: _____

Telephone Number: _____ Claim Number: _____

Policy Number: _____ Medical Payments: _____

Coverage: _____

Your Health Insurance Company Name:_____

Address: _____ Telephone Number: _____

Group Number: _____ Policy Number: _____

Insured's Name: _____

☐ ☐

Do you have: Medicare Medicaid _____

Referral Source:_____ Referred by another client:_____

Advertisement (source): _____

Bar Association: _____

Personal Friend: _____

Other: _____

Attorney Notes

Office Use Did we pull the report: Yes No Do we need to get the report: Yes No

Referral Physician (s): _____

Property Damage settled: Yes No If yes, amount: $_____

Who will handle PD? Us Insurance Client

Do we need to take photos? Yes No If yes, what of? _____