PERSONAL INJURY INTAKE

(Please use additional paper if there is insufficient space for any section)

I. YOUR GENERAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

□ Spouse: _____

Date of Birth: _____ SSN: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

II. YOUR EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____

Weekly/Biweekly Salary: $_____ Date Employment Commenced: _____

No. of Hours Worked Per Day: _____ No. of Days Worked Per Week: _____

Supervisor: _____ Phone No.: _____

Last Day Worked Before Accident: _____

Date Returned: _____ Light/Restricted Duty? _____

How Long Were You Confined to Bed? _____

How Long Were You Confined Home? _____

III. YOUR INSURANCE INFORMATION

A. Do you or your spouse have health and/or disability insurance through your employment? _____ If your answer is "yes", then provide the following information:

Name and address of health insurance company through employment: _____

_____

Employer health insurance company's policy no.: _____

Has health insurance through employment paid any benefits for this accident? _____

If your previous answer is "yes", approximately how much? _____

Name and address of disability insurance company through employment: _____

_____

Employer disability insurance company's policy no.: _____

Has disability insurance through employment paid any benefits for this accident? _____

If your previous answer is "yes", approximately how much? _____

B. Do you have private (not through employment) health or disability insurance? ____ If your answer is "yes", please provide the following information:

Name and address of private health insurance company: _____

_____

Private health insurance company's policy no.: _____

Has your private health insurance paid any benefits for this accident? _____

If your previous answer is "yes", approximately how much? _____

Name and address of private disability insurance company: _____

_____

Priviate disability insurance company's policy no.: _____

Has your private disability insurance paid any benefits for this accident? _____

If your previous answer is "yes", approximately how much? _____

IV. YOUR EDUCATION

High School Name: _____

Address: _____

Graduation Date: _____

Post High School Name: _____

Address: _____

Degree(s) obtained and Date: _____

V. ACCIDENT INFORMATION

Date of Accident: _____ Day: _____ Time: _____

Location of Accident: _____

_____

Was a public governmental authority, agency, or employee possibly at fault?
□ Yes □ No If yes, state whom and why you believe they may be at fault: _____

_____

_____

_____

_____

What is the address or the intersection where the accident occurred? _____

_____

You Were Traveling on What Street/Road? _____

Offending Vehicle Was Traveling on What Street/Road? _____

Weather: _____ Your Position in Vehicle: _____

Describe the accident: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Law Enforcement Dept(s). at scene: _____

_____

Officer(s) name(s): _____

_____

Was there emergency care at scene? □ Yes □ No If your answer is "yes", who/what provided emergency care? _____

Were you transported in an ambulance? □ Yes □ No If your answer is "yes", what is the name of the ambulance service? _____

Was there fire or other rescue care at scene? □ Yes □ No If your answer is "yes", which fire or rescue service? _____

VI. PLEASE DRAW A DIAGRAM OF THE ACCIDENT BELOW:

VII. WITNESSES TO ACCIDENT

Witness #1: Name: _____

Address: _____

Phone Number: _____

Witness #2: Name: _____

Address: _____

Phone Number: _____

Witness #3: Name: _____

Address: _____

Phone Number: _____

VIII. VEHICLE INFORMATION (if applicable)

□ You were the _____ in Vehicle #1 (Owner/Operator/Passenger)

□ You were a pedestrian.

Vehicle No. 1 (Your Vehicle):

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Leaseholder's Address: _____

Operator: _____

Address: _____

Insurance Co.: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

Vehicle No. 2 (other party's vehicle):

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Leaseholder's Address: _____

Operator: _____

Address: _____

Insurance Co.: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

Vehicle No. 3 (other party's vehicle):

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Leaseholder's Address: _____

Operator: _____

Address: _____

Insurance Co.: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

IX. IF NOT ALREADY LISTED ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT ANY PARTY THAT YOU BELIEVE MAY BE AT FAULT:

AT FAULT PARTY #1:

Name: _____

Address: _____

Phone Number: _____

Why do you believe they may be at fault? _____

_____

Their liability insurance company: _____

The address of their liability insurance company: _____

_____

Liability policy holder: _____ Policy no.: _____

Effective date of policy: _____ Expiration date of policy: _____

AT FAULT PARTY #2:

Name: _____

Address: _____

Phone Number: _____

Why do you believe they may be at fault? _____

_____

Their liability insurance company: _____

The address of their liability insurance company: _____

_____

Liability policy holder: _____ Policy no.: _____

Effective date of policy: _____ Expiration date of policy: _____

X. HOSPITALS/CLINICS WHERE YOU HAVE TREATED FOR INJURIES FROM ACCIDENT

Hospital/Clinic #1: _____

Dates of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type: □ ER □ Admission □ Outpatient □ Clinic Visit

Hospital/Clinic #2: _____

Dates of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type: □ ER □ Admission □ Outpatient □ Clinic Visit

Hospital/Clinic #3: _____

Dates of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type: □ ER □ Admission □ Outpatient □ Clinic Visit

Hospital/Clinic #4: _____

Dates of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type: □ ER □ Admission □ Outpatient □ Clinic Visit

XI. PHYSICIANS THAT YOU HAVE SEEN FOR INJURIES FROM ACCIDENT

1. Doctor's Name: _____ Specialty: _____

   Address: _____

   Phone: _____ First Visit: _____

2. Doctor's Name: _____ Specialty: _____

   Address: _____

   Phone: _____ First Visit: _____

3. Doctor's Name: _____ Specialty: _____

   Address: _____

   Phone: _____ First Visit: _____

4. Doctor's Name: _____ Specialty: _____

   Address: _____

   Phone: _____ First Visit: _____

XII. ANY PREVIOUS ACCIDENTS?

Have you ever been involved in a **previous** automobile or any other type of accident?

□ Yes □ No

If yes, complete the following:

Date: _____ Place: _____

Description: _____

_____

_____

_____

_____

Injuries Sustained: _____

_____

_____

_____

_____

List the medical providers who rendered treatment for injuries from prior accident: _____

_____

_____

_____

Did you commence a claim or a lawsuit? □ Yes □ No

If Yes, Please list the name and address of your prior attorney: _____

_____

_____

XIII. OTHER MEDICAL HISTORY

List past physicians of note and current primary or treating physicians below.

1. Doctor's Name: _____ Specialty: _____

   Address: _____

   Phone: _____ First Visit: _____

   Description of Condition(s) You Are or Have Treated for With This Doctor/Provider: ___

   _____

2. Doctor's Name: _____ Specialty: _____

   Address: _____

   Phone: _____ First Visit: _____

Description of Condition(s) You Are or Have Treated for With This Doctor/Provider: ___

_____

3. Doctor's Name: _____ Specialty: _____

Address: _____

Phone: _____ First Visit: _____

Description of Condition(s) You Are or Have Treated for With This Doctor/Provider: ___

_____

4. Doctor's Name: _____ Specialty: _____

Address: _____

Phone: _____ First Visit: _____

Description of Condition(s) You Are or Have Treated for With This Doctor/Provider: ___

_____

Do you have any medical conditions or disabilities that pre-date the accident?

□ Yes □ No

If yes, complete the following:

What: _____

Date(s): _____

Description of How Sufferred: _____

_____

_____

_____

Symptoms/Limitations: _____

_____

_____

_____

List the medical providers who rendered treatment for injuries or symptoms: _____

_____

_____

_____

_____

Do you still suffer from the condition/disability? □ Yes □ No

If no, when did condition/disability end? _____

Date: _____ _____

Signature