CONFIDENTIAL PERSONAL INJURY INTAKE

Date:_____

YOUR INFORMATION

Name: _____

Email Address: _____(be sure this is checked daily)

Mailing Address: _____

County of Residence: _____ County of accident: _____

Phone Numbers: Cell: _____ Home: _____

Work: _____ Emergency: _____

Age: _____ d/o/b: _____ Social Security: _____

If you are currently employed:

Name of Employer: _____

Address: _____

Title/Position: _____

Date Became Employed: _____

Yearly Income: $_____ Bonus/Commissions: $_____

Describe benefits (i.e. company car; per diem, etc): _____

What was your yearly income **from all sources** BEFORE tax deductions?

2010: $_____ 2011: $_____

2012: $_____ 2013: $_____

If you have any gaps in employment, please explain: _____

_____

PERSON RESPONSIBLE FOR ACCIDENT

Name: _____

Mailing Address: _____

County of Residence: _____

PASSENGERS Identify each passenger involved:

Name: _____ my car/ other car Age:_____

Identify their injuries, if any: _____

Name: _____ my car/ other car Age:_____

Identify their injuries, if any: _____

Name: _____ my car/ other car Age:_____

Identify their injuries, if any: _____

_____ (initials)

YOUR CRIMINAL HISTORY

Have you been convicted of a crime? Y N If yes, what crime: _____

County: _____ Date: _____

****You MUST go to the County and obtain a CERTIFIED copy of the conviction!

Have you ever been arrested? Y N If yes, why: _____

County: _____ Date: _____

Identify each traffic citation you have had in the past 10 years:

Citation: _____ Date: _____ County: _____

Citation: _____ Date: _____ County: _____

Citation: _____ Date: _____ County: _____

Vehicles Involved in Collision

Vehicle One Owner: _____ Personal/Business

Make: _____ Model: _____ Year: _____

Identify all damage: _____

Vehicle Two Owner: _____ Personal/Business

Make: _____ Model: _____ Year: _____

Identify all damage: _____

Vehicle Three Owner: _____ Personal/Business

Make: _____ Model: _____ Year: _____

Identify all damage: _____

***** You must provide color pictures to our office ASAP

Health Insurance Information

Primary Medical Insurance: _____ ID: _____

Name of Insured: _____Phone: _____

Fax: _____ Deductible: $_____

Secondary Medical Insurance: _____ ID: _____

Name of Insured: _____Phone: _____

Fax: _____ Deductible: $_____

***** You must provide copies of the front and back of your insurance cards

Car Insurance Information

Carrier: _____ ID: _____

Name of Insured: _____ Phone: _____

Name of Adjuster: _____ Fax: _____

What are your policy limits? _____/_____

Do you have MedPay Y N Amount $_____

Do you have Uninsured Motorist Coverage? Y N Amount $_____

***** You must provide copies of the front and back of your insurance card

_____ (initials)

Police Reports
Were the police called to the scene? Y/N Name of Officer: _____
Did the police issue a citation? Y/N
****You must obtain a copy of the police report and provide us a copy ASAP

Ambulance Information
Were you taken by ambulance? Y N
Name of Ambulance: _____ Phone Number: _____

Emergency Room
Name of Hospital: _____ Phone Number: _____
Treating Doctor: _____
Did you have: MRI CTSCAN XRAY IV
Briefly describe treatment received: _____
_____
_____

Post Emergency Room
Identify all doctors who treated you from the date of the injury to present.
Name of Facility *Name of Doctor* *Contact Phone Number*
_____
_____
_____
_____

Identify all injuries that resulted from the collision: _____
_____
_____
_____

Are you expected to make a full recovery? Y N Are you still treating? Y N
Have you been released from treatment? Y N
If no, please explain: _____

Prior Injuries, Surgeries etc
Briefly describe all previous injuries and surgeries. It is important that you provide accurate information so that we can adequately evaluate your case.
_____
_____
_____

I _____, swear the information contained herein is true and accurate to the best of my knowledge.

_____
Signed

_____ (initials)