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Attorneys at Law

INCIDENT INFORMATION SHEET

CLIENT: Full Name: _____ Driver or Passenger? (please circle)

Spouse's full name, if married: _____

Address: _____ Apt. # _____

City: _____ County: _____ State _____ Zip _____

Social Security No.: _____ Driver's License No.: _____ Date of Birth _____

Home Phone Number: (____) _____ Cell Phone Number: (____) _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father: _____ Telephone (____) _____

Mother: _____ Telephone (____) _____

ACCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ AM or PM?

City of Incident: _____ County of Incident: _____

Road/Intersection: _____

Where the police called to the scene? YES ___ NO ___

Was an accident or incident report filed? YES ___ NO ___

If yes, please state the accident or incident report number: _____

Passenger in car accident? Please give driver's full name: _____

PLEASE EXPLAIN ACCIDENT: _____

_____.

PASSENGERS/COMPANIONS (if applicable): (other people in your car who were injured):

Name: _____ Contact Number: _____

Address: _____

City: _____ County: _____ State _____ Zip _____

Date of Birth: _____ Social Security No.: _____

Driver's License No.: _____

Spouse's Name, if married: _____

INJURIES: _____

Did above go to the hospital? YES ___ NO ___ Name of Hospital _____

Transported by ambulance? YES ___ NO ___ Name of ambulance service _____

Did they take x-rays? YES ___ NO ___ (list all Dr.'s names/address/telephone number) _____

_____.

IS THE ABOVE SEEING A DOCTOR NOW? YES ___ NO ___ (list all Dr.'s name)

_____.

Do you anticipate any loss of earnings due to accident related injuries? YES ___ NO ___

PASSENGERS/COMPANIONS (if applicable): (other people in your car who were injured):

Name: _____ Contact Number: _____

Address: _____

City: _____ County: _____ State _____ Zip _____

Date of Birth: _____ Social Security No.: _____

Driver's License No.: _____

Spouse's Name, if married: _____

INJURIES: _____

Did above go to the hospital? YES ___ NO ___ Name of Hospital _____

Transported by ambulance? YES ___ NO ___ Name of ambulance service _____

Did they take x-rays? YES ___ NO ___ (list all Dr.'s names/address/telephone number) _____

IS THE ABOVE SEEING A DOCTOR NOW? YES ___ NO ___ (list all Dr.'s name)

Do you anticipate any loss of earnings due to accident related injuries? YES ___ NO ___

IF APPLICABLE: PROPERTY DAMAGE

(Damage to your vehicle)

DO YOU NEED HELP IN RESOLVING THE DAMAGE TO YOUR VEHICLE? YES ___ NO ___

IS YOUR VEHICLE DRIVABLE? YES ___ NO ___

Estimated Damage: \$ _____

WHERE IS YOUR VEHICLE LOCATED? _____

Your vehicle's year, make, model and color: _____

Your vehicle plate number: _____

Who is the owner of your vehicle? _____

Do you have clear title to your vehicle? YES ___ NO ___

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

Can you supply us with pictures of your vehicle? YES ___ NO ___

Is your vehicle available for us to take pictures? YES ___ NO ___

IF APPLICABLE: YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto insurance company: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: (_____) _____

Claim Number (if known): _____

Type of Coverage: _____ PIP Limits \$ _____

DEFENDANT INFORMATION: IF APPLICABLE
AUTOMOBILE INSURANCE

Driver's Name: _____ Telephone Number (_____) _____

Address: _____

City: _____ County: _____ State _____ Zip _____

Date of Birth: _____ Driver's License No.: _____

Name of Insurance Carrier: _____

Agent/Adjuster: _____

Telephone Number: _____ Fax Number: _____

Policy Number (if known): _____ Claim Number: _____

DESCRIPTION OF DEFENDANT'S (other driver's) VEHICLE:

Year, make, model and color: _____

Plate Number: _____

Owner's Name, if different from driver: _____

Were there passengers in the other driver's vehicle? YES ____ NO ____

If yes, how many? _____

Were there independent witnesses (individuals who were not involved in the accident who saw what happened)? YES ____ NO ____

Please list the following with respect to any independent witnesses:

Name: _____ Contact Number: _____

Address: _____

Name: _____ Contact Number: _____

Address: _____

Name: _____ Contact Number: _____

Address: _____

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail: _____

Did above go to the hospital? YES ____ NO ____ Name of Hospital _____

Transported by ambulance? YES ____ NO ____ Name of ambulance service _____

Did they take x-rays? YES ____ NO ____

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? YES ____ NO ____

If yes, please list all Doctors: name, address and telephone number: _____

_____.

LOSS OF EARNINGS

IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOW:

Employer: _____
Your position or title: _____
Rate of Pay: \$ _____ or \$ _____ year salary

How many hours do you normally work per week? _____

DO YOU HAVE HEALTH INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insurance Carrier: _____
Name of Policy Holder: _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? YES ____ NO ____
If yes, please state, to whom given and when: _____

PRIOR ACCIDENTS OR INCIDENTS FOR ALL CLIENTS
(Please DO NOT leave blank, if none, so state)

DATE	NATURE OF ACCIDENT OR INCIDENT (Auto, work related, slip & fall, medical neglect, etc.)	INJURIES
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOW WERE YOU REFERRED TO US? _____
Do you currently have a Will? Yes _____ No _____
Have you been denied Social Security benefits? Yes _____ No _____
Have you been denied Veterans Benefits? Yes _____ No _____
Do you have need of legal assistance for any immigration matter? Yes _____ No _____

IF APPLICABLE: WRONGFUL DEATH INFORMATION SHEET

Client(s) relationship to Decedent: _____

Decedent's Name: _____

Address: _____

Decedent's:

Date of Birth: _____ Social Security No.: _____ Driver's License No.: _____

Decedent's Employer: _____

Address: _____

Job Title/Description: _____

Salary wage rate: _____ Length of Time at Employment: _____

Education: High School Yes ___ No ___ Graduated: Yes ___ No ___; College: Yes ___ No ___

Degree: Yes ___ No ___; Post Graduate Yes ___ No ___; Degree: Yes ___ No ___

WAS DECEDENT MARRIED? YES ___ NO ___

NAME OF SPOUSE: _____

CHILDREN: YES ___ NO ___

NAME _____ AGE _____

ADDRESS: _____ PHONE # _____

NAME _____ AGE _____

ADDRESS: _____ PHONE # _____

NAME _____ AGE _____

ADDRESS: _____ PHONE # _____

NAME _____ AGE _____

ADDRESS: _____ PHONE # _____