DAVIS, FRAWLEY, ANDERSON, MCCAULEY, AYER, FISHER & SMITH, LLC
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 <u>other driver's</u> 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 # ___________________