

PERSONAL INJURY SIGN UP FORM

Date: _____ How did you find us? _____
Client: _____ Male: ___ Female: ___
Address: _____ City: _____
State: _____ Zip Code _____ E-mail _____
Phone: () _____ Fax: () _____ Marital Status: _____
D.O.B. _____ S.S.N. _____
Place of Birth: _____
Minor: No ___ Yes ___
Mother: _____ Father: _____
Guardian: _____
Parent SS#: _____ Drivers License # _____ State: _____

***Emergency contact for client such as family member or friend if an important issue comes up and we can not reach client at their address or phone number:

Please supply a name and phone number:

Name: _____ Relationship: _____
Address: _____
Phone #: () _____

ACCIDENT INFORMATION

D/A: _____ Time: _____ a.m./p.m.
Police Dept. & Case No.: _____
Location of Accident: _____
Client's Description of Accident: _____

Driver: ___ Passenger: _____
Wearing Seat belt? ___ If no, why? _____
Owner of vehicle: _____
Description of vehicle involved in accident:
Year: _____ Make: _____ Model: _____ Color: _____
Damaged Areas: _____
Current Location of vehicle: _____
Do you have photographs? _____



EMPLOYER

Were you working at the time of the accident?: Yes _____ No _____
Employer: _____
Address: _____
Telephone No.: () _____
Wage rate: _____ per hour
Date(s) lost from work: _____

MEDICAL TREATMENT

Transported by Ambulance? _____ If so, name of company: _____
Were you admitted: _____ Length of stay: _____

Dr/Hospital	Address	Phone #	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe injuries: _____

INSURANCE

CLIENT AUTOMOBILE INSURANCE:

Name of Insured: _____
Carrier: _____
Address: _____ Phone: () _____
Policy #: _____ Claim #: _____
Adjuster: _____

HOST VEHICLE INSURANCE:

Owner's Name: _____ Phone: () _____
Address: _____
Carrier: _____
Address: _____
Policy #: _____ Claim #: _____

INTAKE



CLIENT HEALTH INSURANCE:

Carrier: _____ Phone: () _____
Type: PPO _____ HMO _____ Group # _____
Address: _____
MEDICARE: _____ If so, Medicare #: _____
MEDICAID: _____ If so, Medicaid #: _____

****HAS A WRITTEN OR RECORDED STATEMENT BEEN GIVEN TO ANYONE?****

Name: _____ Ins. Co.: _____

DEFENDANT INFORMATION

DEFENDANT #1/OWNER:

Name: _____ Phone #: () _____
Address: _____
Carrier: _____ Phone #: () _____
Address: _____
Agent: _____ Phone #: () _____
Policy #: _____ Claim #: _____
Adjuster: _____ Insured: _____

DEFENDANT #2/DRIVER:

Name: _____ Phone #: () _____
Address: _____
Carrier: _____ Phone #: () _____
Address: _____
Agent: _____ Phone #: () _____
Policy #: _____ Claim #: _____
Adjuster: _____ Insured: _____

PRIOR ACCIDENTS

Prior Insurance Claims: Yes _____ No _____
Prior Attorneys for PI or WC injuries: _____
Address: _____ Phone: () _____
Describe any prior injuries: _____

COMMENTS/ADDITIONAL INFORMATION:

