

PERSONAL INJURY INTAKE FORM

CLIENT'S INFORMATION

Full Legal Name: _____	
Residence Address: _____	
Phone: _____	Email: _____
Date of Birth: _____	SSN: _____
State/License Number: _____	Spouse's Name: _____

EMPLOYER INFORMATION

Company: _____	Phone: _____
Address: _____	
Salary: _____	Payroll Contact: _____
Is this a work related injury?	____ Yes ____ No
If yes, has workmans comp been filed?	____ Yes ____ No
Have you lost wages as a result of this injury?	____ Yes ____ No
Are you off work now?	____ Yes ____ No
Date you expect to return: _____	
If no employer, source of income: _____	

YOUR AUTOMOBILE INFORMATION

Make/Model: _____	Plate No. _____
Purchase Info: _____	Cost: _____ Balance Owed: _____
Registered Owner: _____	Phone: _____
Address: _____	

For Office Use Only

Client Name: _____	File Number: _____	Date: _____
Reviewing Attorney: _____	Added to Matter by: _____	Date: _____

AUTO INFO (continued)

Lienholder: _____	Phone: _____
Address: _____	
Insurance Company: _____	Phone: _____

Address: _____	
Policy Number: _____	Claim Number: _____
Have you notified Insurance Company?	___ Yes ___ No
Did you need to rent a car?	___ Yes ___ No
If yes, which company? _____	

MEDICAL BACKGROUND

Have you been in an accident before?	___ Yes ___ No	How many? _____
Were you injured?	___ Yes ___ No	How many? _____
Was Insurance Company involved?	___ Yes ___ No	
Name of Insurance Company: _____		
Did you receive a settlement?	___ Yes ___ No	How much? _____
Describe accident(s), Date(s) and Injuries:		

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WORKERS COMP

Have you been in any workers comp claims? Yes No How many? _____

Were you injured? Yes No How many?

Was Insurance Company involved? Yes No

Name of Insurance Company: _____

Did you receive a settlement? Yes No How much? _____

Describe accident(s), Date(s) and Injuries:

LIENS

Are there any parties (Medicare/Welfare) that will have a claim against the proceeds you receive as a settlement? Yes No

If yes, explain:

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ACCIDENT

Type of Accident:	Automobile	Pedestrian	Work	Other
Date/time of Accident:	_____			
Location of Accident:	_____			
Your car was going (N, S, E, W) on Street:	_____			
Other driver was going (N, S, E, W) on Street:	_____			
No. Lanes Each Way:	_____	Were you wearing your seatbelt?	___ Yes ___ No	
Describe Incident:	_____ _____ _____ _____ _____ _____ _____			
Describe Injuries:	_____ _____ _____ _____ _____			

BUSINESS WHERE ACCIDENT HAPPENED (If Applicable)

Company:	_____	Phone:	_____
Address:	_____		
Name of contact:	_____	Title:	_____
		Phone:	_____

<u>For Office Use Only</u>			
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		Date:	_____
		Date:	_____

WITNESSES (If Applicable)

Name: _____	Phone: _____
Address: _____	
Relation: _____	
Name: _____	Phone: _____
Address: _____	
Relation: _____	

AMBULANCE (If Applicable)

Company: _____	Phone: _____
Address: _____	
Account Number: _____	Charges: _____
Submitted to Insurance Co?	___ Yes ___ No
If yes, provide insurance company information:	
Company: _____	Phone: _____
Address: _____	

HOSPITAL

#1	
Company: _____	Phone: _____
Address: _____	
Account Number: _____	Charges: _____
Submitted to Insurance Co?	___ Yes ___ No

For Office Use Only

Client Name: _____	File Number: _____	Date: _____
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HOSPITAL (continued)

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

#2 (If Applicable)

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

PHYSICIAN

#1

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

For Office Use Only

Client Name: _____

File Number: _____

Date: _____

Reviewing Attorney: _____

Added to Matter by: _____

Date: _____

PHYSICIAN (continued)

#2 (If Applicable)

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

#3 (If Applicable)

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

PHYSICAL MEDICINE (Chiropractic, Physical Therapy, Etc)

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

For Office Use Only

Client Name: _____

File Number: _____

Date: _____

Reviewing Attorney: _____

Added to Matter by: _____

Date: _____

PHYSICAL MEDICINE (Continued)

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

#2 (If Applicable)

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

#3 OTHER (If Applicable)

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? _____ Yes _____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

OTHER DRIVER INFORMATION

Full Legal Name: _____

Residence Address: _____

Phone: _____ Date of Birth: _____

For Office Use Only

Client Name: _____

File Number: _____

Date: _____

Reviewing Attorney: _____

Added to Matter by: _____

Date: _____

OTHER DRIVER (continued)

State/License Number: _____	
Make/Model: _____	Plate No. _____
Registered Owner: _____	Phone: _____
Address: _____	
Insurance Co. _____	Policy No. _____
PIP application, have you signed/sent any forms to this insurance company? ___ Yes ___ No	

POLICE ASSISTANCE (If Applicable)

Name of Agency: _____		
Office Name: _____	Phone: _____	Date: _____

PLEASE ATTACH ALL INVOICES FOR EACH MEDICAL PROVIDER LISTED AND RETURN WITH THIS FORM

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