

NEW CASE INFORMATION

D/FILE OPENING: _____

D/ACCIDENT: _____

SOL: _____

NATURE OF CASE: _____

OTHER DEADLINE: _____

CLIENT DATA

NAME: _____

ADDRESS: _____ APT. #: _____

CITY, ST, ZIP: _____

SOCIAL SECURITY NUMBER: _____

HOME PHONE: _____

EMPLOYER: _____

WORK PHONE: _____

OTHER PHONE: _____

DATE OF BIRTH: _____

SPOUSE'S NAME: _____

E-MAIL ADDRESS: _____

REFERRAL SOURCE: _____

DRIVER'S LICENSE #: _____ STATE: _____

a. Any restrictions? _____

b. Any citations, including DUI, in the last 3 years? _____

EMPLOYER: _____

a. How long? _____

b. Occupation? _____

c. Rate of Pay? _____

d. Time lost from work? _____

e. Fringe benefits lost? _____

f. Date returned to work? _____

g. Any work limitations? _____

Marital Status: (check one)

Single

Married

Separated

Divorced

a. Spouse's name: _____

b. Spouse's employer: _____

c. Work phone: _____

ACCIDENT DATA

Do you have a copy of the accident report? _____

injured in client's vehicle: _____

a. Name(s): _____

Wearing seatbelts? _____

Was accident job-related? _____

a. If yes, is Workers' Comp paying your medical bills?

b. If yes, name, address & phone # of Workers' Comp benefits provider:

Property Damage: _____

Have you given a statement about the collision to anyone? _____

a. If yes, to whom did you give the statement? _____

b. Name, address & phone # of insurance company: _____

c. Was your statement recorded? _____

d. Have you signed any documents provided by the above – identified person or
insurance company? _____

Has the adjuster discussed settlement of your person injury claim? _____

Amount offered: \$ _____

Has the adjuster discussed settlement of your property damage claim? _____

Amount offered: \$ _____

Present location of the vehicle: _____

Legal owner of the vehicle: _____

Did you have prior injuries? _____

What are your injuries? _____

CLIENT'S INSURANCE INFORMATION

Client's insurance company: _____

Policy #: _____

Uninsured Motorist limits: \$ _____

Medical Payment benefits: \$ _____

Adjuster: _____ Phone #: _____

Claim #: _____

Other auto insurance: _____

Hospitalization/Health insurance: _____

MEDICAL INFORMATION

Health prior to accident: _____

Prior hospitalizations: (Please include year, facility & reason for hospitalization, i.e. surgery, illness)

Prior illnesses: _____

Broken bones? (If yes, when?) _____

Prior neck and/or back problems? (If so, when? Who treated you?) _____

Have you ever suffered prior injury to any part of your body which was injured in this accident?

(If yes, what was injured? When? Who treated you?) _____

Which physicians and/or facilities have treated you thus far for the injured you sustained as a result of this collision? (Please provide name and address, if possible)

MISC. INFORMATION

Any prior automobile accident? _____

a. If yes, when and where? _____

b. Were you injured? _____

Any prior claims for damages? _____

a. Property damage? _____

b. Workers' Comp? _____

c. Other? _____

Any prior claims for personal injury? _____
