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PERSONAL INJURY CLIENT INTAKE FORM

Name: _____ **DOB:** _____

Social Security Number: _____

Date of Injury: _____

Phone number: _____

1. How did the accident occur? _____

2. Describe your injuries resulting from this accident: _____

3. Have you sought medical attention? Y or N Still treating? Y or N

When?

4. Total medical bills incurred to date? _____

5. Doctor(s) Name Address Phone number:

6. Medical diagnosis? _____

7. Was there a Police/Accident report? Y or N Do you have a copy of it? Y or N

8. Please list your lost wages to date: _____

Your employer:

Rate of pay: _____ **Date of Hire?** _____

FOR AUTO ACCIDENTS:

1. Estimate amount in dollars to repair your vehicle? _____

2. Area of your vehicle that was damaged?

3. Location of accident? _____

4. Did other driver have insurance? Y or N Do you have ins.? Y or N

5. Your insurance company: _____

Address: _____

Phone No.: () _____

