

DESCRIPTION OF INCIDENT

WHAT STATEMENTS WERE MADE BY YOU TO THE POLICE OFFICER?

WHAT DID THE OTHER DRIVER SAY? _____

WHERE IS THE VEHICLE LOCATED? _____

DID YOU GIVE A RECORDED STATEMENT TO ANYONE RE THE COLLISION? "P Q" [GU

IF SO, NAME OF PERSON/COMPANY _____

TRAFFIC COURT DATE, IF APPLICABLE. _____

NAMES OF **WITNESSES**, OTHER PARTIES _____

ADDRESS AND PHONE NUMBER _____

CLIENT'S INSURANCE INFORMATION

CLIENT'S AUTOMOBILE INSURANCE

CO. _____

ADDRESS: _____

PHONE: _____

ADJUSTER: _____

CLAIM NO.: _____

POLICY NO.: _____

MEDPAY LIMITS _____

UM LIMITS: _____

SUBRO/LIENS _____

RENTAL COVERAGE _____

HEALTH INSURANCE

CO.: _____

GROUP NO.: _____

ID NO.: _____

ADDRESS: _____

PHONE: _____

SUBRO/LIENS _____

OTHER POSSIBLE COVERAGES

DOES CLIENT OWN ANY OTHER AUTOMOBILES? _____

DOES ANY **RELATIVE** WHO LIVED WITH CLIENT OWN ANY CARS? _____

IF CLIENT WAS A PASSENGER OR WAS DRIVING ANOTHER PERSON'S VEHICLE IN THE COLLISION,
LIST THE CAR'S AUTO INS. BELOW

CO. _____

ADDRESS: _____

PHONE: _____

POLICY NO.: _____

MEDPAY LIMITS: _____

UM LIMITS: _____

CO. _____

ADDRESS: _____

PHONE: _____

POLICY NO.: _____

MEDPAY LIMITS: _____

UM LIMITS _____

PAIN & SUFFERING

MARITAL STATUS: _____ SPOUSE'S NAME _____

CHILDREN: NO YES IF SINGLE PARENT, IS THERE ANY CHILD

NAMES & AGES _____ SUPPORT? "P Q" [GU

HOBBIES & ACTIVITIES

LIST SEVERAL HOBBIES & ACTIVITIES THAT THE CLIENT HAS NOT BEEN ABLE TO DO

PROPERTY DAMAGE

VEHICLE: _____ MODEL NO.: _____

FAIR MARKET VALUE (use NADA) _____

LIENHOLDER _____ PAYOFF: _____

ADDRESS _____

ACCOUNT NUMBER: _____ PHONE NUMBER _____

MISCELLANEOUS

DID ANY OTHER ATTORNEY REPRESENT YOU FOR THIS INCIDENT? "P Q" [GU "P Q

IF SO, NAME AND ADDRESS _____

HAVE YOU TAKEN PICTURES OF YOUR CAR? "YES NO

IF NOT, CAN PICTURES STILL BE TAKEN? "YES NO

Required items: pictures of vehicle, bruises, lacerations, medical equipment, etc.

OPPOSING PARTY INFORMATION

OWNER OF VEHICLE

NAME: _____

ADDRESS: _____

PHONE: _____

MAKE/MODEL: _____

TAG NO.: _____

DRIVERS LIC.: _____

LIABILITY INSURANCE

CO.: _____

ADDRESS: _____

PHONE: _____

ADJUSTER: _____

CLAIM NO.: _____

POLICY NO.: _____

DRIVER OF VEHICLE

NAME: _____

ADDRESS: _____

PHONE: _____

DRIVERS LIC: _____

DATE OF BIRTH: _____

CITATION GIVEN: "*****"YES NO

TYPE: _____

INDEPENDENT ADJUSTER

CO.: _____

ADDRESS: _____

ADJUSTER: _____

PHONE: _____

FILE NO.: _____

PASSENGERS

NAME: _____

ADDRESS: _____

PHONE: _____

NAME: _____

ADDRESS: _____

PHONE: _____

REMEMBER, IF THE OWNER AND DRIVER'S ADDRESSES ARE THE SAME BUT ARE DIFFERENT PEOPLE,
THERE MAY BE ADDITIONAL LIABILITY INSURANCE.

MEDICAL INFORMATION

DESCRIPTION OF INJURIES AND COMPLAINTS OF PAIN TIME OF LOSS:

INJURIES AND PAIN THAT DEVELOPED LATER:

WERE YOU EVER IN A PRIOR AUTOMOBILE ACCIDENT? "*****YES NO

IF YES, WERE YOU INJURED? PROVIDE DETAILS<

HAVE YOU EVER INJURED YOURSELF WHILE SLIPPING AND FALLING?*****[GU*****P Q

IF YES, PROVIDE DETAILS_____

HAVE YOU EVER MADE A CLAIM AGAINST AN INSURANCE COMPANY? "*****[GU*****P Q

MEDICAL TREATMENT

HOW MANY DAYS AFTER THE COLLISION DID YOU SEEK YOUR FIRST MEDICAL

TREATMENT?_____

AMBULANCE:_____

HOSPITAL/EMERGENCY ROOM_____

DOCTORS/PHYSICAL THERAPY, ETC.

NAME:_____

NAME:_____

ADDRESS:_____

ADDRESS:_____

PHONE:_____

PHONE:_____

NAME:_____

NAME:_____

ADDRESS:_____

ADDRESS:_____

PHONE:_____

PHONE:_____