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CONFIDENTIAL CLIENT QUESTIONAIRE

Thank you for allowing us to assist you in your injury case. Please take the time to complete each and every question. I understand that this may be an inconvenience for you, but each question is highly important to your case. As partners, we must help each otehr in obtaining full knowledge and understanding of all information surrounding the incident including information that cound hinder your case.

PERSONAL INFORMATION

FULL NAME: _____ TELEPHONE NUMBER: _____

OTHER NAMES KNOWN BY: (INCLUDING MAIDEN) _____ SOCIAL SECURITY #: _____

CURRENT FULL ADDRESS: (INCLUDING CITY, & STATE) _____ DRIVER'S LICENSE #: _____

MAILING ADDRESS: (IF DIFFERENT) _____ MARITAL STATUS: _____

SPOUSE NAME (IF ANY): _____

CHILD(S) NAMES AND DATE OF BIRTH (IF ANY): _____

OCCUPATION

CURRENT EMPLOYER: _____ JOB TITLE: _____

EMPLOYERS FULL ADDRESS: (INCLUDING CITY & STATE) _____ HOW LONG EMPLOYED: _____

RATE OF PAY: _____ MAY WE CONTACT YOUR EMPLOYER: _____ WORK TEL.: _____

LAST DAY WORKED BEFORE ILLNESS OR INJURY: _____ LAST DAY WORKED BEFORE ILLNESS OR INJURY: _____

LIST ALL DATES AND NUMBER OF HOURS MISSED DUE TO INJURY: _____

BRIEFLY DESCRIBE YOUR JOB DUTIES: _____

_____

_____

_____

CLIENT INITIALS

INCIDENT INFORMATION

DATE OF INJURY: _____ TIME OF INJURY: _____

LOCATION (CROSSROADS, INTERSECTION): _____ COUNTY: _____

WEATHER CONDITIONS: _____ HAVE YOU HAD ANY PRIOR SLIP OR FALL CASES: _____

IF YOUR INJURIES WERE SUSTAINTED FROM A TRAFFIC ACCIDENT:

A: PLEASE INDICATE IF YOU WER THE DRIVER, PASSENGER, PEDESTIRAN AND IF YOU WER THE PASSENGER, WHO WAS THE DRIVER?

_____

B: IF YOUR INJURIES WERE SUSTAINED FROM A TRAFFIC ACCIDENT PLEASE SPECIFY THE MAKE, MODEL, AND TYPE OF VEHICLE YOU WERE IN:

_____

C: HAS YOUR VEHICLE EVER BEEN IN A PREVIOUS ACCIDENT?

_____

WAS THE POLICE CALLED? _____ IF SO, WHICH AGENCY ARRIVED? _____

WAS THE FIRE DEPARTMENT CALLED? _____ IF SO, WHICH AGENCY ARRIVED? _____

LIST ANY CITATION GIVEN AND TO WHOM: _____

_____

WAS A POLICE REPORT COMPLETED? _____ DO YOU HAVE A COPY OF THE POLICE REPORT? _____

DESCRIBE WHAT HAPPENED: _____

_____

_____

_____

DRAW A DIAGRAM OF THE ACCIDENT SCENE:

_____

CLIENT INITIALS

INSURANCE INFORMATION

VEHICLE OF WHICH YOU WERE THE DRIVER/PASSENGER AT THE TIME OF ACCIDENT:

VEHICLE (YEAR /MAKE/MODEL): _____ PLATE NUMBER: _____

DESCRIBE DAMAGE TO YOUR VEHICLE: _____

_____

LOCATION OF YOUR VEHICLE: _____ WAS THE PROPERTY DAMAGE RESOLVED: _____

WERE PHOTOGRAPHS TAKEN? _____ AREAS PHOTOGRAPHED: _____

NAME AND FULL ADDRESS OF INSURANCE COMPANY:

_____

POLICY/ INSURED (IF NOT YOU): _____ POLICY NUMBER: _____

CLAIM NUMBER: _____ ADJUSTER NAME: _____

TELEPHONE NUMBER: _____ POLICY LIMITS: _____

PERSONAL INJURY PROTECTION APPLICATION (MEDPAY) COMPLETED? _____

VEHICLE OF WHICH YOU WERE THE DRIVER/PASSENGER AT THE TIME OF ACCIDENT:

VEHICLE (YEAR /MAKE/MODEL): _____ PLATE NUMBER: _____

DESCRIBE DAMAGE TO YOUR VEHICLE: _____

_____

LOCATION OF YOUR VEHICLE: _____ WAS THE PROPERTY DAMAGE RESOLVED: _____

WERE PHOTOGRAPHS TAKEN? _____ AREAS PHOTOGRAPHED: _____

NAME AND FULL ADDRESS OF INSURANCE COMPANY:

_____

POLICY/ INSURED (IF NOT YOU): _____ POLICY NUMBER: _____

CLAIM NUMBER: _____ ADJUSTER NAME: _____

TELEPHONE NUMBER: _____ POLICY LIMITS: _____

PERSONAL INJURY PROTECTION APPLICATION (MEDPAY) COMPLETED? _____

YOUR HEALTH INSURANCE COMPANY:

COMPANY NAME: _____ POLICYHOLDER / INSURED: _____

POLICY / ID NUMBER: _____

ADDRESS: _____ _____

_____

CLIENT INITIALS

OTHER PARTY INFORMATION

NAME: _____ TEL. NO.: _____

ADDRESS: _____

DRIVER'S LICENSE NO.: _____ VEHICLE PLATE NO.: _____

NAME AND FULL ADDRESS OF INSURANCE COMPANY:

_____

POLICY/ INSURED _____ POLICY NUMBER: _____

CLAIM NUMBER: _____ ADJUSTER NAME: _____

TELEPHONE NUMBER: _____ POLICY LIMITS: _____

PERSONAL INJURY PROTECTION APPLICATION (MEDPAY) COMPLETED? _____ RECORDED STATEMENT? YES / NO

WITNESS INFORMATION

NAMES OF ANY WITNESSES (PLEASE INCLUDE ADDRESS AND TELEPHONE NUMBERS, IF KNOWN):

INJURIES / MEDICAL TREATMENT

1. LIST ALL INJURIES THAT YOU RECEIVED AS A RESULT OF THIS ACCIDENT:

2. LIST THE NAMES OF EVERY HOSPITAL WHERE YOU HAVE BEEN TREATED SINCE THE ACCIDENT OCCURRED, WHETHER OR NOT YOU WERE TREATED FOR INJURIES CAUSED BY THE ACCIDEENT. INCLUDE THE DATE OF ADMISSIONS, NAME OF HOSPITAL, AND REASONS FOR EACH HOSPITALIZATION:

3. LIST THE NAMES, ADDRESSES, AND TELEPHONE NUMBER OF ALL DOCTORS WHO HAVE TREATED YOU FOR YOUR INJURIES:

_____

CLIENT INITIALS

4. DESCRIBE EVERY PAST INJURY, ACCIDENT, INCLUDING WORK-RELATED ACCIDENTS, IN WHICH YOU HAVE EVER BEEN INVOLVED. (INCLUDE DATE, TIME, LOCATION, TYPE OF ACCIDENT, AND INJURIES):

5. LIST ALL ILNESSES OR INJURIES FOR WHICH YOU WERE BEING TREATED AT THE TIME OF THE ACCIDENT ALONG WITH THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE TREATING PHYSICIAN:

6. LIST ANY MEDICATIONS FOR WHICH YOU WERE TAKING DURING THE TIME OF THE ACCIDENT:

7. LIST EVERY PAST MEDICATION TAKEN FOR MORE THAN TWO WEEK INCREMENTS AND THE REASON FOR THE MEDICATION:

8. WERE X-RAYS TAKEN OF YOUR INJURIES:

9. IF YES, PLEASE PROVIDE THE DATE AND LOCATION:

10. WHEN IS YOUR NEXT DOCTORS APPOINTMENT (INCLUDE DOCTORS NAME AND LOCATION):

11. HAVE YOU EVER HAD SURGERY? IF SO, PLEASE PROVIDE THE DATE, LOCATION, NAME OF DOCTOR, AND REASON:

12. ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE LIST THE MEDICATION(S) AND DESCRIBE YOUR REACTION TO THIS MEDICATION:

13. LIST ALL MEDICAL BILLS INCURRED DUE TO THE ACCIDENT. (INCLUDE NAME OF MEDICAL PROVIDER AND APPROXIMATE AMOUNT OWING):

14. WERE PHOTOGRAPHS TAKEN OF THE INJURIES?

CLIENT INITIALS