INTAKE SHEET

Plaintiff(s) Information:

▪ **CLIENT NAME**: _____

DATE OF INCIDENT: _____ TIME: _____ a.m./p.m. DAY OF THE WEEK: _____

LOCATION: _____

CITY, COUNTY, STATE: _____

DESCRIBE EVENT: _____

_____

_____

_____

CLIENT INFORMATION

Telephone _____ Date of Birth _____

Social Security _____ Driver's License No._____

Address _____

E-mail Address: _____

Spouce/Partner Name: _____

Children: _____

▪ **Employer** _____ position _____

Telephone _____ Facsimile _____

Address _____

Salary / # of years with co.: _____

Have you incurred any lost wages? _____

Emergency Contacts

Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ E-mail Address: _____

- **Do you have Health Insurance:** YES/NO **Health Provider Name** _____

  Member #_____ Group #_____

  Telephone _____ Facsimile _____

  Mailing Address _____

- **Do you have Medicaid:** YES/NO

  Member #_____ Group #_____

  Telephone _____ Facsimile _____

  Mailing Address _____

- **Do you have Medicare** YES/NO

  Member #_____ Group #_____

  Telephone _____ Facsimile _____

  Mailing Address _____

- **Do you have Workers Compensation:** YES/NO

  Company: _____

  Rate of Compensation: _____ Benefits Began: _____

  Benefits Exhausted: _____ Days/Months Out of Work: _____

  Released: _____

  Supervisor: _____

  WC Insurance Co.: _____

  Company Doctor: _____

Accident Information

- Police Department _____ Incident # _____

  Officer _____ Were there any tickets issued? _____

  Defendant _____ Telephone _____

  Were there any witnesses? _____ Telephone _____

  Were any photographs taken at the scene? _____

  In your own words, may you please describe the incident to the best of your ability?

  _____

  _____

  _____

  _____

- **Client's Vehicle Information**

  Year, Make, Model _____

  and VIN # _____ License Plate# _____

  Owner of vehicle _____ Is there a lien holder? _____

  Location of vehicle _____

  Do you need a Rental Car? _____ Which Rental Company would you prefer_____

  List all passengers in vehicle: 1.) _____

  2.) _____

- **Insurance Carrier_____ Policy Number _____**

  Adjuster _____ Claim Number _____

  Telephone _____ Facsimile _____

  Mailing Address _____

  Do you have Uninsured Motorist Coverage? YES/NO Do you have Personal Injury Protection Coverage? YES/NO

  Have you filed a claim under your PIP or UM/UIM YES/NO Claim Number _____

- **What are your symptoms / injuries?**

  _____

  _____

  _____

Did you require the services of an ambulance? _____

Hospital/Emergency Room Information

Hospital __ _____ Date(s) of Service _____

Telephone _____ Facsimile _____

Mailing Address _____

Please list all treating medical providers seen pertaining to the accident:

1.) _____ 2.) _____

Tel_____ Tel_____

Date(s) of Service: _____ Date(s) of Service: _____

Do you have any out-of-pocket expenses? (Prescriptions. Etc.)_____

Do you have any prior medical history? _____

_____

_____

Have you previously been involved in any car accidents? _____

_____

Have you ever been convicted of a crime? _____

_____

Defendant Information:

▪ Other Driver _____ Telephone _____
Driver's License _____ Date of Birth _____

Address _____

▪ Vehicle
Year, Make, Model and VIN ____ _____

Owner of vehicle _____ License Plate _____

▪ **Insurance Carrier__ ____ _____ Policy Number _____ _____ ___**

Adjuster _____ Claim Number _____

Telephone _____ Facsimile _____

Mailing Address _____