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| **General Information** |
| Full Legal Name: |  |
| Preferred Name: |  |
| Age: |  |
| Birthdate: |  |
| Social Security Number: |  |
| Email Address: |  |
| Home Address: |  |
| Home Phone: |  |
| Cell Phone: |  |
| Work Phone: |  |
| Marital Status: |  |
| * Spouse’s Name:
 |  |
| Dependents: |  |

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| **Employer Information** |
| Company Name: |  |
| Address: |  |
| Job Description: |  |
| Length of Employment: |  |
| Rate: |  |
| Lost Time: |  |
| Other: |  |

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| **Accident Information** |
| Date: |  |
| Time: |  |
| Location: |  |
| Description of Accident: |  |
| Defendant’s Name: |  |
| Address: |  |
| Police Department: |  |
| Officer: |  |
| Tickets Given to: |  |
| Witnesses: |  |
| Road Conditions: |  |
| Statements Given: |  |

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| **Client’s Vehicle** |
| Make/Model: |  |
| Damage to: |  |
| Client’s Insurer: |  |
| Policy Limits: |  |
| Claim Number: |  |

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| **Defendant’s Vehicle** |
| Make/Model: |  |
| Damage to: |  |
| Client’s Insurer: |  |
| Policy Limits: |  |
| Claim Number: |  |

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| **Premises/Dram Shop** |
| Name: |  |
| Address: |  |

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| **Damages** |
| Injuries: |  |
| Hospital: |  |
| Doctors: |  |
| Has your doctor given you a no-work slip? |  | No |
|  | Yes |
|  | * If Yes, state the name of the doctor and dates they took you off work:
 |
|  |

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| **Plaintiff’s Health Insurance** |
| Insurance Company Name: |  |
| Insurance Company Address: |  |
| Is it group health insurance through an employer? |  | No |
|  | Yes |

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| **Prior Injuries/Claims** |
| Date of Accident: |  |
| Location of Accident: |  |
| Type of Injury: |  |
| Treated by: |  |
| Claim or Lawsuit: |  |
| Attorney who Handled: |  |

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| **Comments:** |
|  |

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| **Statute of Limitations** |
| One Year: |  |
| Six Months: |  |
| Three Months: |  |
| Two Months: |  |
| One Month: |  |
| Three Weeks: |  |
| Two Weeks: |  |
| One Week: |  |
| DUE: |  |