

WELCOME!



A PROFESSIONAL ASSOCIATION

AUTO INJURY INTAKE

DATE OF ACCIDENT: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE TELL US ABOUT YOURSELF

First Name: \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of Mobile provider? \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status:  Single  Married, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Name: \_\_\_\_\_

Separated, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Divorced, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Widowed, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Children:  Yes  No If yes, how many? \_\_\_\_\_

Highest school grade completed: \_\_\_\_\_

Do you have a current driver's license, or identification card?

Yes /  No If so: State of \_\_\_\_\_

Driver's License # \_\_\_\_\_

Email Address: \_\_\_\_\_

PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE

How did you hear about our office? (Please check all that apply)

TV  Internet  Road Sign  Relative  Friend  Former Client  Phone Book  Referral Service

Other, please explain: \_\_\_\_\_

**PLEASE TELL US ABOUT YOUR ACCIDENT**

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident: \_\_\_\_:\_\_\_\_  AM  PM

Date Employer Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ Person Notified: \_\_\_\_\_

Accident Location: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Accident Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Which law enforcement agency responded to the accident? \_\_\_\_\_

Do you know of any witnesses to accident, or persons with knowledge of accident?  Yes  No

If so, please list below:

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PLEASE TELL US ABOUT YOUR ACCIDENT INJURIES**

Injuries You Received: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you go to the ER / hospital? \_\_\_\_\_ If yes, which hospital? \_\_\_\_\_

Were you taken by ambulance? \_\_\_\_\_ If no, how did you get there? \_\_\_\_\_

**PLEASE TELL US ABOUT THE HOSPITALS/CLINICS WHERE YOU WERE TREATED**

Hospital/Clinic: \_\_\_\_\_ Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital/Clinic: \_\_\_\_\_ Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital/Clinic: \_\_\_\_\_ Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital/Clinic: \_\_\_\_\_ Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital/Clinic: \_\_\_\_\_ Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**LIST THE DOCTORS WHO YOU HAVE SEEN IN THE ORDER YOU SAW THEM**

Physician #1: \_\_\_\_\_ Dates Seen: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Injury: \_\_\_\_\_

Physician #2: \_\_\_\_\_ Dates Seen: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Injury: \_\_\_\_\_

Physician #3: \_\_\_\_\_ Dates Seen: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Injury: \_\_\_\_\_

Physician #4: \_\_\_\_\_ Dates Seen: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Injury: \_\_\_\_\_

Physician #5: \_\_\_\_\_ Dates Seen: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Injury: \_\_\_\_\_

**HAS ANY DOCTOR GIVEN YOU A DISABILITY RATING?**

Rating Physician: \_\_\_\_\_ MMI Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Rating: \_\_\_\_\_ %

Rated Injury: \_\_\_\_\_

Rating Physician: \_\_\_\_\_ MMI Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Rating: \_\_\_\_\_ %

Rated Injury: \_\_\_\_\_

**WHO IS YOUR FAMILY PHYSICIAN?**

Name: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip : \_\_\_\_\_

How long has he/she been your family physician? \_\_\_\_\_

**PLEASE TELL US ABOUT YOUR VEHICLE**

Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Color: \_\_\_\_\_

Odometer Reading: \_\_\_\_\_ At time of accident: \_\_\_\_\_ Currently: \_\_\_\_\_

Options: \_\_\_\_\_

Lienholder Name: \_\_\_\_\_ Lienholder Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Loan Number: \_\_\_\_\_

PLEASE TELL US ABOUT **YOUR** AUTOMOBILE INSURANCE CARRIER

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PLEASE TELL US ABOUT THE **OTHER** DRIVER'S AUTOMOBILE INSURANCE CARRIER

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

INJURIES/ACCIDENTS YOU HAVE HAD BEFORE YOUR ACCIDENT

Have you had ANY injuries prior to this accident that required medical attention? Please tell us:

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Types of injuries: \_\_\_\_\_ Legal action taken? \_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Types of injuries: \_\_\_\_\_ Legal action taken? \_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Types of injuries: \_\_\_\_\_ Legal action taken? \_\_\_\_

PLEASE TELL US ABOUT YOUR EMPLOYMENT AT THE TIME OF YOUR INJURY

EMPLOYER #1

Occupation: \_\_\_\_\_ Work Responsibilities: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Benefits Coordinator: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Length of Employment: \_\_\_\_\_ Years \_\_\_\_\_ Months

Hours per Week: \_\_\_\_\_ Pay Rate: \_\_\_\_\_ Gross Pay Per Week: \_\_\_\_\_

Fringe Benefits: \_\_\_\_\_

EMPLOYER #2

Occupation: \_\_\_\_\_ Work Responsibilities: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Benefits Coordinator: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Length of Employment: \_\_\_\_\_ Years \_\_\_\_\_ Months

Hours per Week: \_\_\_\_\_ Pay Rate: \_\_\_\_\_ Gross Pay Per Week: \_\_\_\_\_

Fringe Benefits: \_\_\_\_\_

PLEASE TELL US ABOUT YOUR **CURRENT EMPLOYMENT** **IF DIFFERENT** FROM ABOVE

Employer's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ Benefits Coordinator: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Length of Employment: \_\_\_\_\_ Years \_\_\_\_\_ Months  
Hours per Week: \_\_\_\_\_ Pay Rate: \_\_\_\_\_ Gross Pay Per Week: \_\_\_\_\_

PLEASE TELL US ABOUT THE STATUS OF YOUR CASE

Have you missed time from work?  Yes  No Was the accident work-related?  Yes  No  
How much time have you missed from work: \_\_\_\_\_ Are you still off work?  Yes  No  
Are you receiving any wage-loss benefits?  Yes  No If so, what is the amount of your bi-weekly check: \$ \_\_\_\_\_  
Do you have medical expenses unpaid?  Yes  No Do you have lost wages unpaid?  Yes  No

PLEASE TELL US ABOUT YOUR HEALTH INSURANCE / DISABILITY INSURANCE

Do you have health insurance?  Yes  No If yes, which health insurance company: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Member I.D. #: \_\_\_\_\_ Other #: \_\_\_\_\_  
Do you receive  SOCIAL SECURITY DISABILITY  MEDICARE  SSI  MEDICAID?  
Has your HEALTH INSURANCE or MEDICARE / MEDICAID paid any of your bills?  Yes  No  
Do you have Short or Long Term Disability insurance?  Yes  No  
If yes, name of Disability Insurance Company: \_\_\_\_\_

PLEASE TELL US ABOUT ANY DIFFICULTIES YOU ARE HAVING

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF YOU HAVE BEEN PREVIOUSLY REPRESENTED BY AN ATTORNEY FOR **THIS** ACCIDENT, PLEASE TELL US

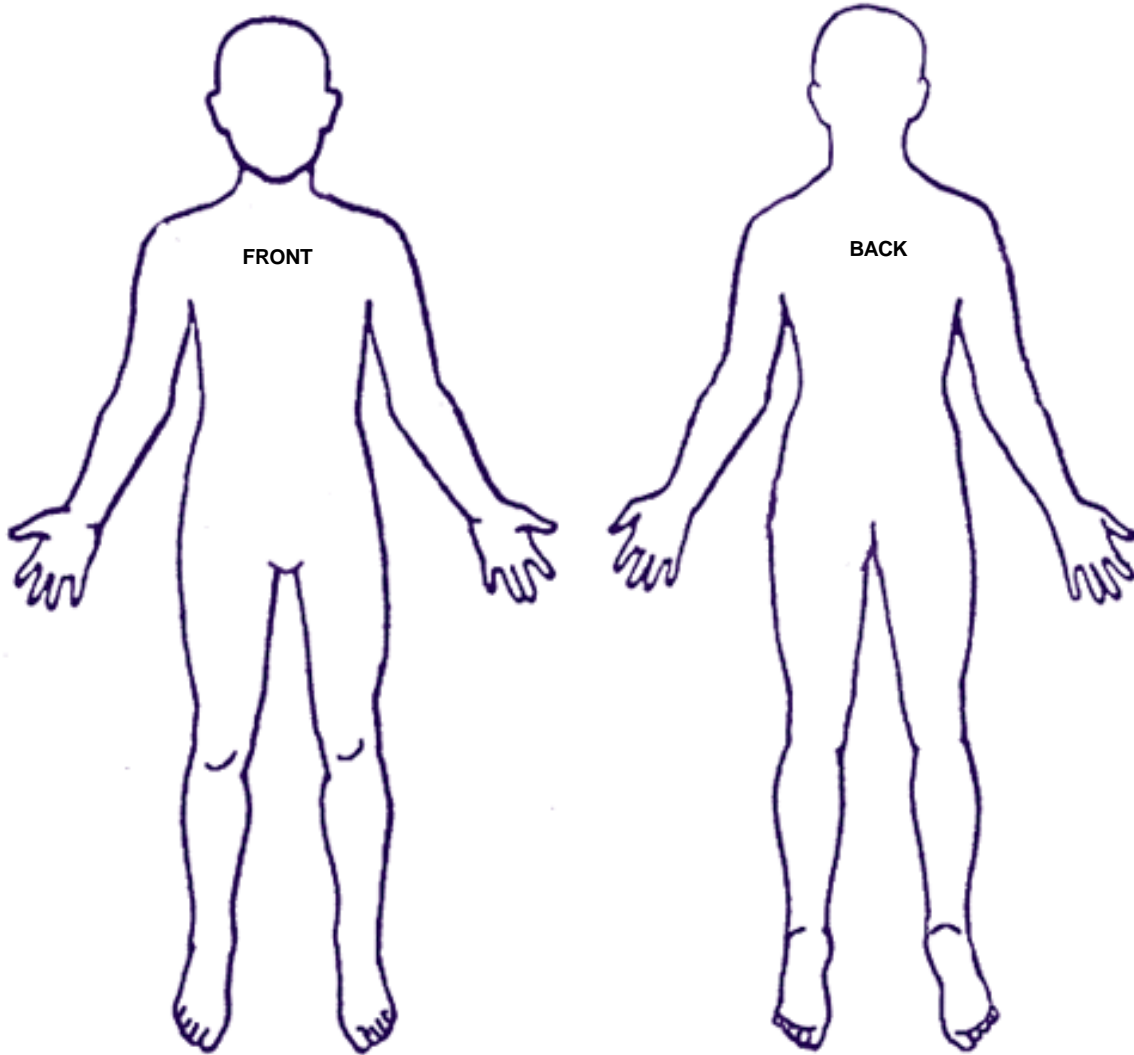
Attorney Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

FOR OFFICE USE ONLY:

Intake Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Statute of Limitations: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ON THE DIAGRAM, PLEASE CIRCLE OR PLACE AN X  
ON THE PART(S) OF YOUR BODY THAT WAS INJURED



PLEASE DRAW ON THE DIAGRAM HOW YOUR ACCIDENT OCCURRED.

Use the diagram to reconstruct the locations of the cars and witnesses. Show the direction of travel of all the vehicles, the location of traffic signals and signs and any other markings or characteristics of the scene.

