

WELCOME!



A PARTNERSHIP OF PROFESSIONAL ASSOCIATIONS

PERSONAL 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 _____

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 / INCIDENT

Date of Accident: ____/____/____ Time of Accident: ____:____ AM PM
Date Employer Notified: ____/____/____ Person Notified: _____
Accident Location: _____
City: _____ County: _____ State: _____
Accident Description: _____

Which law enforcement agency, if any, 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 ____/____/____

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? _____

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 yes, 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

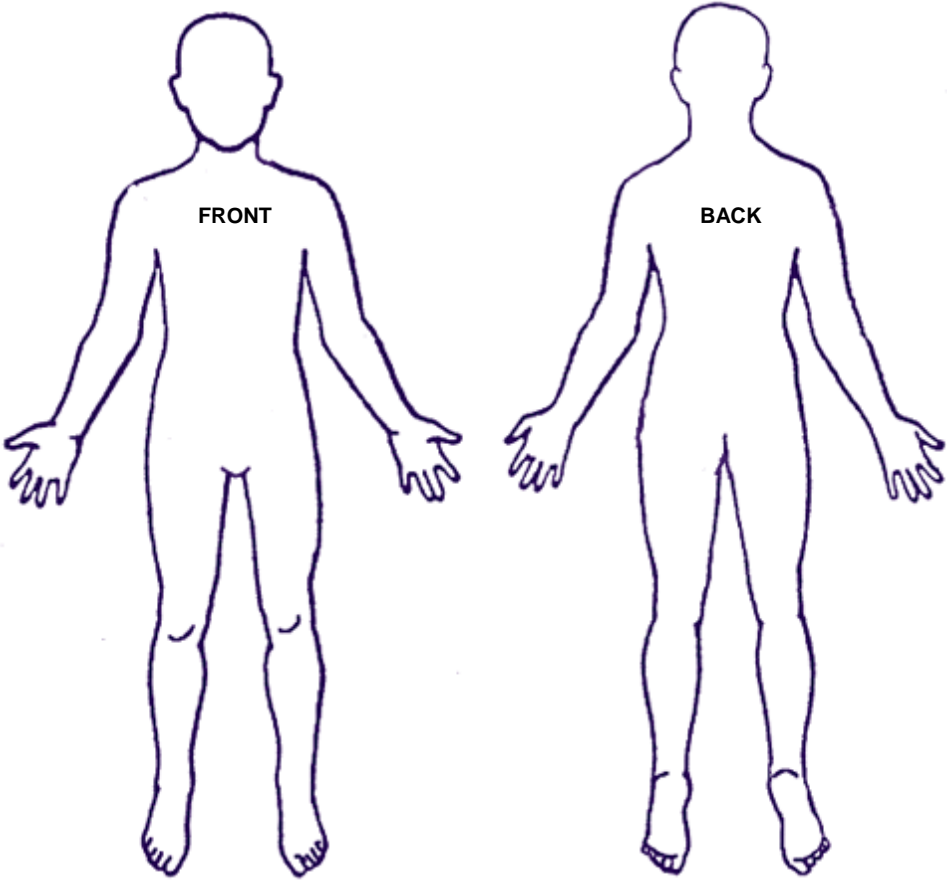
Do you have health insurance? Yes No If yes, which health insurance company: _____
Policy #: _____ Member I.D. #: _____ Other #: _____
Do you receive SOCIAL SECURITY DISABILITY MEDICARE SSI MEDICAID?
Has your HEALTH INSURANCE or MEDICARE / MEDICAID paid any of your bills? Yes No
Do you have Short or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

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



FOR OFFICE USE ONLY:

Intake Date: ____/____/____ Statute of Limitations: ____/____/____

Notes: _____

