

ATTORNEY INFORMATION

Law Firm: _____ Attorney Name: _____ Mr. Ms.
 Law Firm Contact Name (if not attorney): _____ Paralegal Case Manager Asst. Other
 State: _____ Email: _____ Phone: (____) ____ - ____ Office Cell

CLIENT INFORMATION

Full Name: _____ Mr. Ms. Language: English Spanish Other _____
 Phone: (____) ____ - ____ Email: _____ DOB: ____ - ____ - ____ SSN: ____ - ____ - ____
 Address: _____ City: _____ State: ____ Zip Code: _____
 Client Type: Driver Passenger Pedestrian Cyclist Other _____ Was client employed at time of injury? Yes No

CASE INFORMATION

Incident Date: ____ - ____ - ____ Police Department: _____ Police / Incident Report: Attached N/A
 Police Report Number: _____ Number of Claimants: _____ Is this Workers' Compensation? Yes No
 Accident: Rear-End Sideswipe Side-Impact Head-on T-Bone Rollover Slip & Fall/Bodily Injury Other _____
 Road Type: Highway Intersection Parking Lot Street Other Property Damage? Total Loss Repairable \$ _____
 Brief Description: _____
 Has client been involved in a prior accident(s)? Yes No If yes, list incident date(s) and type(s) of injuries sustained in each:

 Does client have any pre-existing health conditions? Yes No If yes, state the nature of client's pre-existing conditions:

 Client Vehicle: Year ____ Make _____ Model _____ Adverse Vehicle: Year ____ Make _____ Model _____

ADVERSE/DEFENDANT INSURANCE INFORMATION

Liability Accepted? Yes No Investigating Policy Limits \$ _____ Policy/Claim #: _____
 Insured Full Name: _____ Insurance Company: _____ Phone: (____) ____ - ____

CLIENT/PLAINTIFF INSURANCE INFORMATION

Type(s) of Coverage/Limits: UM UIM Med-Pay PIP Limits Available: \$ _____ Policy/Claim #: _____
 Insurance Company: _____ Phone: (____) ____ - ____ Is client Medicare or Medicaid insured? Yes No
 Did client carry private health insurance at the time of incident? Yes No Is client Medicare or Medicaid eligible? Yes No
 When do you anticipate this claim to settle? 0-2 Months 3-6 Months 7-9 Months 10-12 Months 1-2 Years 2+ Years

TREATMENT INFORMATION

Medical Bills to date (estimate): \$ _____ Type of Treatment to date: _____
 Ambulance? Yes No Description of Injuries: _____
 Hospital? Yes No If yes, Hospital Name: _____ City: _____ State: _____
 Date of First Treatment? ____ - ____ - ____ Treatment requested: Physical Therapy MRI/Imaging Ortho-Extremity Ortho-Spine
 Pain Management Neurology Psychological Evaluation Initial Medical Evaluation Other _____

OTHER INFORMATION

Is there any additional information you would like to include that may be helpful?
