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:____

____

(Turn Over for page 2)

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: ____

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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: ____

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____

____

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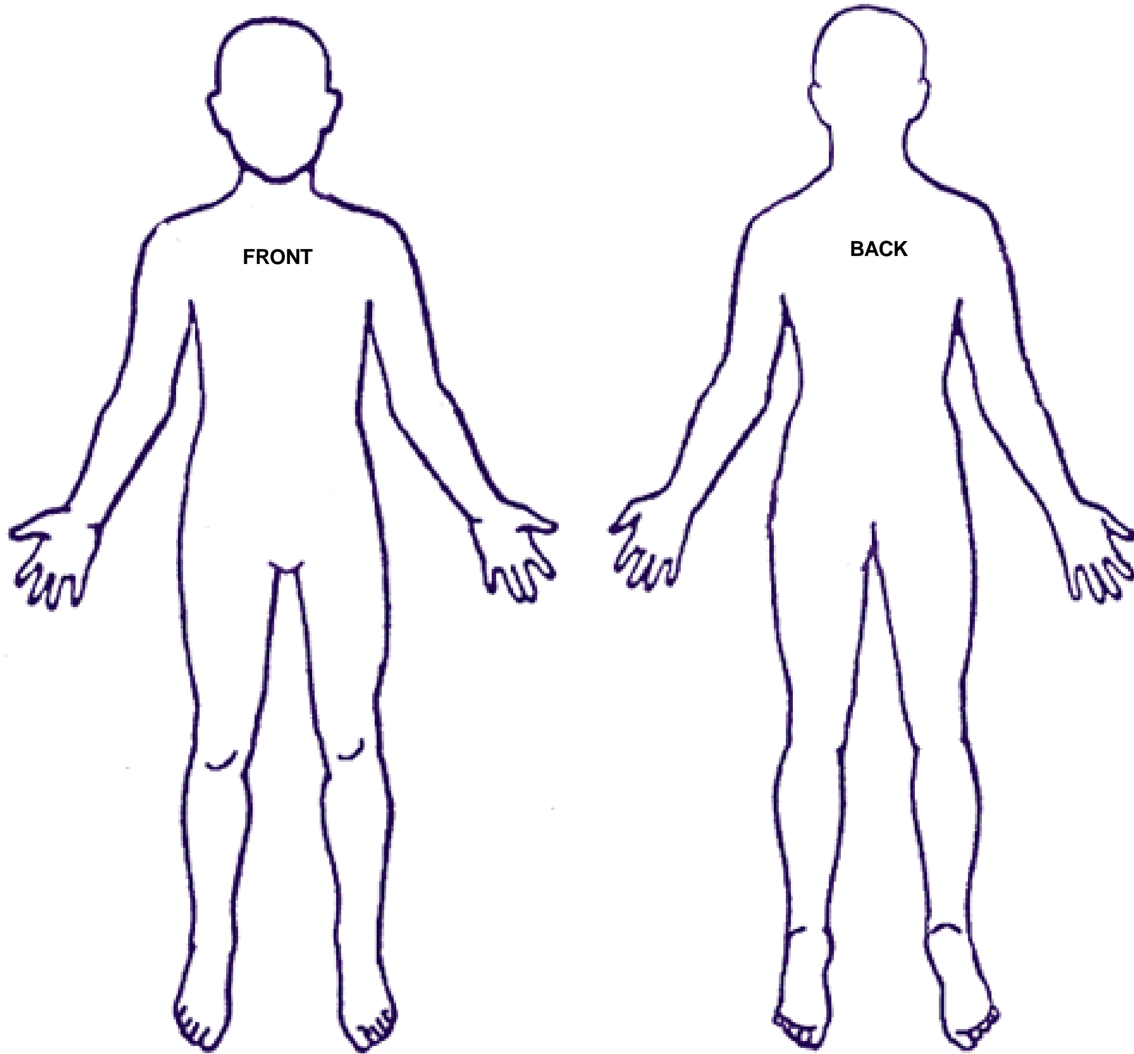
ON THE DIAGRAM, PLEASE CIRCLE OR PLACE AN X
ON THE PART(S) OF YOUR BODY THAT WAS INJURED



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.