

Police Called to Scene?: YES NO

Report Filed? YES NO (Type?: _____) (By whom?: _____)

To your recollection, how did the incident in question transpire?

PASSENGER INFO: Who was with you? (if this applies):

Name: _____

Address: _____
Street City State Zip Code

Phone: _____

Date of Birth: _____

Driver's License #: _____

Injuries They Sustained (if any): _____

Was this individual transported to a hospital? YES NO Hospital Name: _____

Was this individual transported by an emergency vehicle? YES NO Service Name: _____

Is this individual currently seeing a doctor in relation to injuries sustained? YES NO

Do you anticipate any loss of earnings, due to accident-related injuries? YES NO

VEHICULAR/PROPERTY DAMAGE INFO:

Is your vehicle drivable?: YES NO

What is the estimated damage amount?:\$ _____

VEHICLE INFO:

Make: _____

Model: _____

Year: _____

VIN #: _____

Plate #: _____

Is the TITLE on your vehicle clear? YES NO

Who owns the vehicle in question? _____

Do you currently have pictures of your vehicle following the incident? YES NO

Is your vehicle available for us to take pictures? YES NO

AUTO INSURANCE INFO:

Name of your auto Insurance Carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: _____

Claim Number (if known): _____

Type of Coverage: _____ PIP Limits: \$ _____

III. Post-Incident Information

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail:

Did you go to the hospital? YES NO

Name of Hospital _____

Did you go by ambulance? YES NO

Name of Ambulance Service _____

Did they take x-rays? YES NO

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE INCIDENT, OTHER THAN AT THE EMERGENCY ROOM? YES NO

If yes, please list all Doctors: Name, Address and Telephone Number

LOSS OF EARNINGS (IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING):

Employer: _____

Your position or title: _____

Rate of Pay: \$ _____ / hour -or- \$ _____ /year (salary)

How many hours do you normally work per week? _____

DO YOU HAVE HEALTH INSURANCE? (IF YES, PLEASE COMPLETE THE FOLLOWING):

Name of Insurance Carrier: _____

(please circle one) PPO HMO Medicaid Other _____

Name of Policy Holder: _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? YES NO

If yes, please state, to whom given and when: _____

ANY PRIOR ACCIDENTS (not solely automobile) OR INCIDENTS FOR ALL CLIENTS (Please DO NOT leave blank, if none, write "NONE")

DATE / NATURE OF ACCIDENT OR INCIDENT / INJURIES SUSTAINED / TYPE (auto, work related, slip & fall, medical negligence)?

How were you referred to us? (Please circle one)

I am a previous client

Office sign

Web Site

Erie County Bar Association

Referring Attorney

Former/Current Client

Name of person who referred you: _____

Their address: _____

Their telephone: _____