DATE:___________

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Attorneys at Law
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GENERAL PERSONAL INJURY INFORMATION FORM

I. Basic Client Information

Client Name: ____

Spouse's full name, if married ______________________________________ Married / Single / Divorced / Separated (circle one)

Home Address: ____
Street City State Zip Code

Date of Birth: ______________________ Social Security #: __________________ Driver's License #:___________________________

Phone: (Home) _____________________________ (Work) ___________________________ (Mobile) ____________________________

Email: _________________________________ , ________________________________

Emergency Contact: (Name) ____ (Address) _____________________________________

Phone #: _________________________________

If client is a minor under NYS law, please complete:

Father's Name: ______________________________________ Mother's Name: ______________________________________

Telephone #: ______________________________ Telephone #: _______________________________

II. Accident Information

Date of Incident: _________ /____________ / __________

Time of Incident: _______:_______________ am / pm

Location of Incident: ____ ________________________________ (physical location)

____ (address, if any)
Street City State Zip Code County

Police Called to Scene?: YES ☐ NO ☐

Report Filed? YES ☐ NO ☐ (Type?: _________________________) (By whom?: ____________________________)

To the best of your recollection, how did the incident in question occur?

____

____

____

____

____

____

Did you go to the hospital? YES ☐ NO ☐

Name of Hospital ____

Did you go by ambulance? YES ☐ NO ☐

Name of Emergency Service ____

Did they take X-rays? YES ☐ NO ☐

Type of injury?

- Aircraft accident ☐
- Animal bite or attack ☐
- Defective premises ☐
- Defective product ☐
- Police negligence ☐
- Medical malpractice ☐
- Motor vehicle accident ☐
- Slip or trip and fall ☐
- Water-related accident ☐
- Other ___________________ ☐

Who do you believe caused or is responsible for your injury, and why?

____

____

____

____

____

III. Injuries

Please describe your injuries and/or pain (in detail):

____

____

____

____

____

____

____

____

List all doctors and other health care providers who have treated your injuries, including their names, addresses, and telephone numbers.

(**If more room is needed, you may continue the list at the end of this form)*

NAME	***ADDRESS***	***PHONE #***

An estimate of total medical expenses incurred **to date** to treat your injuries: $______________________________

An estimate of total medical expenses you **expect** to incur in the future: $__________________________________ (*write "UNKNOWN" if you do not know*)

INSURANCE INFO: *List the names, addresses, and telephone numbers of all insurance companies that may be involved (including, as applicable, automobile insurer, health insurer, disability insurer, homeowner's insurer, etc.).*

Name of your Insurance Carrier: ____

Name of Policy Holder: ____

Policy Number: ____

Agent/Adjuster: ____

Telephone Number: ____

Claim Number (if known): ____

Type of Coverage: _______________________________

III. Post-Incident Information

Describe any other ways in which your life has changed as a result of your injuries. (For example, you are no longer able to engage in thletic activities, your appearance has changed, you cannot care for your children, etc.)

____

____

____

If married, has your spouse experienced any losses as a result of your injury? If so, describe.

____

____

____

____

List the names, addresses, and phone numbers of any possible witnesses in your case.

NAME	***ADDRESS***	***PHONE #***

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? ____________

Have you given a recorded statement to anyone? YES □ NO □

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

____

Have you previously consulted an attorney regarding your case? YES □ NO □

If yes, provide the attorney's name(s), the firm name(s), the address(es), and the telephone number(s).

____

Attorney Name Firm Address Phone

Has any attorney declined to represent you in this matter? YES □ NO □

ANY PRIOR ACCIDENTS 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: ____