

DATE: _____

LAW OFFICES *of*
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Also Admitted in Florida

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.

<i>NAME</i>	<i>ADDRESS</i>	<i>PHONE #</i>

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
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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: _____