

AUTO PERSONAL INJURY INFORMATION SHEET

TODAY'S DATE: _____ REFERRED BY: _____ CASE TYPE: _____

PERSONAL INFORMATION:

YOUR NAME: _____ YOUR EMAIL: _____

ADDRESS: _____ CITY/ST: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ YOUR CELL NUMBER: () _____

DATE OF BIRTH: _____ LANGUAGE SPOKEN: _____ HOME NUMBER:() _____

YOUR SPOUSE NAME: _____

EMERGENCY CONTACT: _____ EMERGENCY NO.: () _____

(To find you when your benefits arrive)

YOUR EMPLOYER: _____

ADDRESS: _____ TELEPHONE () _____

SALARY/COMMISSIONS: _____ WAGES LOST TO DATE: _____

DETAILS OF ACCIDENT:

DATE OF ACCIDENT: _____ TIME: _____ COUNTY OF ACCIDENT: _____

LOCATION (Cross Streets): _____ CITY: _____

DESCRIPTION OF ACCIDENT: _____

POLICE DEPARTMENT: _____ **POLICE REPORT NO:** _____

YOUR AUTOMOBILE (YEAR/MAKE/MODEL): _____ PHOTOS TAKEN: YES NO

OWNER: _____ ESTIMATE DAMAGE: _____

WAS THE ACCIDENT REPORTED TO YOUR AGENT? YES NO AGENT NAME: _____

AGENT ADDRESS: _____ TELEPHONE NO.: () _____

INSURANCE INFORMATION (PIP)

YOUR AUTO INSURANCE: _____ ADJUSTER NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: () _____ CLAIM NUMBER: _____

YOUR HEALTH INSURANCE: _____ MEMBER ID NO.: _____

MEDICAL TREATMENT:

INJURIES SUSTAINED: _____

AMBULANCE OR RESCUE UNIT: _____ HOSPITAL: _____

LIST DOCTORS YOU HAVE SEEN:

DOCTOR (1) _____ TELEPHONE: () _____

DOCTOR (2) _____ TELEPHONE: () _____

DOCTOR (3) _____ TELEPHONE: () _____

AT-FAULT PARTY INFORMATION:

NAME OF AT-FAULT PARTY: _____ ADJUSTER NAME: _____

AT-FAULT PARTY INSURANCE: _____ INS. PHONE NO.: () _____

INSURANCE ADDRESS: _____ CLAIM NO.: _____

PRIOR ACCIDENTS/INJURIES? YES NO LIST YEARS OF INJURIES: _____

BODY PARTS INJURED: _____ SETTLEMENTS: _____

IF YES, LIST DOCTORS TREATED WITH:

_____ PHONE: () _____

_____ PHONE: () _____

PRIOR PSYCHIATRIC CARE? YES NO DATES: _____

CLIENT'S SIGNATURE