191 Roswell Street
Suite 200
Marietta, GA 30060
404-526-9955

315 West Solomon Street
Suite 140
Griffin, GA 30223
678-603-1119

PERSONAL INJURY CLIENT INFORMATION SHEET

CLIENT INFORMATION:

Name: ______________________________

Address: ______________________________

Home #: ______________ Cell #: ______________

Work #: ______________ Email: ______________

D.O.B.: ______________ S.S.N.: ______________

Name of Spouse: ______________________________

Has your spouse suffered a loss of consortium as a result of the accident? If so, please list the nature of the loss:

____

____

REFERRED BY: ______________________________

EMPLOYER INFORMATION:

Employed by: ______________________________

Supervisor: ______________ Contact Number: ______________

Address: ______________________________

Your Job Title: ______________

Your Job Duties: ______________________________

Date First Employed: ______________ No. Hours Per Week: ______________

Current Rate of Pay: ______________

Have you missed any days of work as a result of this accident? If so, please list dates of loss: ______________

____

INSURANCE INFORMATION:

Client's Insurance: ______________________________

Address: ____________________

Policy Number: ____________________ Do you have Med-Pay Coverage?: ____________________

Do you have Health Insurance?:____________________

Medicare or Medicaid (Circle One) Policy Number: ____________________

At-Fault Party Information:

Driver Name: ____________________ Vehicle Owner same as Driver?: ____________________

Insurance Company: ____________________

Address: ____________________

Policy Number: ____________________

ACCIDENT INFORMATION:

Date of Accident: ____________________ Time of Accident: ____________________

Location of Accident (including County): ____________________

Is the owner of the vehicle different from you? If so, please list the name, address, and telephone number of the owner of the vehicle: ____________________

____

Name of the Law Enforcement Agency who investigated the accident:____________________

Cause of Accident: ____________________

____

____

Were you transported to the Emergency Room from the scene of the accident by ambulance? ____________________

What is the year, make, model, and mileage of your vehicle? ____________________

Do you have photographs of the damage to your vehicle? ____________________

Do you have photographs of the other party(s) vehicle? ____________________

Where is your vehicle currently located? ____________________

INJURY INFORMATION:

Please list all of your injuries: ____________________

____

____

Do you have any photographs of your injuries: ____________________

TREATING HOSPITAL(S):

Name: ____________________

Address: ____

Date Treated: ________________ Were X-rays Taken: __________________

Name: ____

Address: ____

Date Treated: ________________ Were X-rays Taken: __________________

TREATING PHYSICIAN(S):

Name: ____

Address: ____

Date Treated: ________________ Were X-rays Taken: __________________

Name: ____

Address: ____

Date Treated: ________________ Were X-rays Taken: __________________

PRIOR ACCIDENT INFORMATION:

1. Have you ever been involved in a motor vehicle accident before? ____________________
2. If so, state the date(s) and location(s) of any prior accident(s)?______________________________
3. Have you ever been injured in any accident or fall of any kind before?
4. If so, state the date(s) and location (s) of any prior injury you have suffered?__________________
5. In any of the above prior accident or injury, did you file a claim ? ___________________________
6. If so, please state the nature of the claim and the date(s) the claim was made: ____________________

WITNESS INFORMATION:

Name: ____

Address: ____

Telephone: ________________ Email: __________________

Name: ____

Address: ____

Telephone: ________________ Email: __________________

Name: ____

Address: ____

Telephone: __________________ Email: ____________________