PERSONAL INJURY INTAKE

I. CLIENT INFORMATION

Last Name:_____ First Name:_____

MI:_____

Date of Birth:_____SSN: _____

Street

Address:_____

City:_____ State:_____

Zip:_____

Home Phone:_____ Work Phone:_____

Pager/Cell Phone:_____

E-mail:_____

? Spouse: ? Guardian:

Date of Birth: _____ SSN:

_____

Child: _____ DOB: _____

Child: _____ DOB: _____

II. ACCIDENT INFORMATION

Date of Accident: _____ Day: _____ Time: _____

Location Of Accident:

_____

Client Was Traveling On What Street/Road:

_____

Who was responsible for the Accident?_____

_____

His/Her insurance company and policy #: _____

Accident Description:

_____

_____

_____

_____

_____

_____

Officer's Name: _____

Officer's Badge No.: _____

Report No.: _____

III. INJURIES

Injuries Sustained:

_____

_____

Emergency Care At Scene?

Ambulance: Yes ☐ No ☐

A. Hospitals

Hospital #1:

_____

Date Of Treatment: _____ Date Of Discharge:

_____

Address: _____

Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

B***. Physicians***

1. Doctor's Name: _____

Address:

_____

Phone: _____

2. Doctor's Name: _____

Address:

_____

Phone: _____

3. Doctor's Name: _____

Address: _____

Phone: _____ First Visit:

List the medical providers who rendered treatment: _____

_____

List ALL current primary or treating physicians below.

1. Doctor's Name: _____ Specialty:

_____

Address:

_____

Phone: _____ First Visit:

_____

2. Doctor's Name: _____ Specialty:

_____

Address:

_____

Phone: _____ First Visit:

_____

V. WITNESSES

Names of Witnesses, Addresses and Phone Numbers:

_____

_____

_____

_____