



Describe what happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Draw a diagram of accident scene:

### INSURANCE INFORMATION

Vehicle (Year/Make/Model): \_\_\_\_\_  
Plate Number: \_\_\_\_\_  
Describe damage to your vehicle: \_\_\_\_\_  
Location of your vehicle: \_\_\_\_\_  
Property damage resolved? Yes \_\_\_\_\_ No \_\_\_\_\_  
Were photos taken? \_\_\_\_\_ Location of photos: \_\_\_\_\_

#### 1. Vehicle in Which You Were Driver/Passenger at time of Accident

Auto Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policyholder/Insured (If Not You): \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Adjuster Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Policy Limits: \_\_\_\_\_ PIP application completed? Yes \_\_\_\_\_ No \_\_\_\_\_

#### 2. Your Vehicle (If Different) or Vehicle on which You Are Named Insured or Household Member

Auto Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policyholder/Insured (If Not You): \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Adjuster Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Policy Limits: \_\_\_\_\_ PIP application completed? Yes \_\_\_\_\_ No \_\_\_\_\_

3. **Were You On the Job at the Time of the Accident?** Yes \_\_\_\_\_ No \_\_\_\_\_

Workers' Compensation Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Insured: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

4. **Your Health Insurance Company:** \_\_\_\_\_

Address: \_\_\_\_\_

Policyholder: \_\_\_\_\_ ID/Policy Number: \_\_\_\_\_

### OTHER PARTY INFORMATION

#### Other Party #1

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_

Vehicle: \_\_\_\_\_ Plate Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Policy Limits: \_\_\_\_\_ Recorded statement given? Yes \_\_\_\_\_ No \_\_\_\_\_

#### Other Party #2

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_

Vehicle: \_\_\_\_\_ Plate Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Policy Limits: \_\_\_\_\_ Recorded statement given? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*For additional defendants, use the back of this form.**

### WITNESS INFORMATION

Names of any witnesses: (Please include addresses and telephone numbers, if known.)

\_\_\_\_\_  
Name Address Phone

\_\_\_\_\_  
Name Address Phone

\_\_\_\_\_  
Name Address Phone

\_\_\_\_\_  
Name Address Phone

**INJURIES/MEDICAL TREATMENT**

List all INJURIES that you received as a result of this accident. \_\_\_\_\_

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List the names of every HOSPITAL you have been seen at since the accident occurred whether or not you were treated for injuries caused by the accident. Include dates and reasons for each hospitalization.

Date of Admission	Hospital	Reason

List the names and addresses of all DOCTORS who have treated you for your injuries.

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List the names and addresses of all PHYSICAL THERAPISTS who have treated you for your injuries.

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Describe every past injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.)

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List all illnesses or injuries for which you were being treated at the time of the accident.

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### ADDITIONAL BACKGROUND INFORMATION

List every claim or lawsuit in which you have been involved in any way. Include approximate year, parties involved, reasons, and results.

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Have you ever been arrested? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the following information:

Date: \_\_\_\_\_ Charge: \_\_\_\_\_

Have you ever been convicted of a crime? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the following information:

Date: \_\_\_\_\_ Charge: \_\_\_\_\_

Date: \_\_\_\_\_ Charge: \_\_\_\_\_

Result (fine, penalty, etc.): \_\_\_\_\_

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Have you ever filed bankruptcy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the following information:

Date: \_\_\_\_\_ Location: \_\_\_\_\_

Have you ever been represented by another attorney? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Reason: \_\_\_\_\_

Give any other information you feel we should have to represent you effectively in this case \_\_\_\_\_

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Please give a brief summary of what you think a fair outcome would be in your case.

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All items below are needed to complete your personal injury file, if they apply to your case. Bring in originals, or copies as soon as possible.

Items needed:

- Tax returns with schedules and W-2s - last two years
- Paycheck stubs from last two months
- No-Fault Proof of Insurance
- Health Insurance card
- Health Insurance policy
- Disability Insurance policies - short or long term
- Medical bills from all doctors or hospitals
- Explanation of benefits from all insurance companies