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PERSONAL INJURY FACT SHEET

CLIENT INFORMATION

(Driver or Passenger)

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ MARITAL STATUS _____
EMAIL ADDRESS _____ DRIVER'S LICENSE # _____ STATE ISSUED _____
EMPLOYER _____ EMPLOYER'S ADDRESS _____
EMPLOYER PHONE # _____ SUPERVISOR _____ JOB TITLE _____

DETAILS OF THE ACCIDENT

DATE OF ACCIDENT _____ DAY _____ TIME _____
LOCATION OF ACCIDENT _____
WEATHER CONDITIONS _____ VISIBILITY _____
DESCRIPTION OF ACCIDENT _____

WITNESSES' NAMES, ADDRESSES, PHONE NUMBERS _____

WERE THE POLICE AT THE SCENE? YES ___ NO ___ If Yes, officer's name and badge number _____

POLICE DEPARTMENT _____

WAS A POLICE REPORT PREPARED? YES ___ NO ___ If Yes, report number _____

WERE THERE ANY PASSENGERS IN YOUR VEHICLE? YES ___ NO ___ (If Yes, list their names, addresses and phone numbers _____)

VEHICLE INFORMATION

YEAR AND MAKE OF VEHICLE: _____ TAG # _____

DRIVER _____ DRIVER ADDRESS _____

PHONE # _____ DRIVER'S LICENSE _____

OWNER'S NAME _____ OWNER ADDRESS _____

OWNER'S PHONE # _____ INSURANCE AGENT _____

DAMAGE TO VEHICLE _____

VEHICLE TOWED? _____

DED. AMT. _____ AMT. COV. _____

RENTAL INFO. _____

DO YOU HAVE PHOTOGRAPHS OF THE DAMAGE? YES ___ NO ___

YOUR INSURANCE INFORMATION

ACCIDENT REPORTED TO INSURANCE COMPANY? _____
INSURANCE COMPANY: _____ POLICY # _____
HAVE YOU RECEIVED NO FAULT (PIP) FORMS? YES ___ NO ___
PIP INSURANCE CARRIER _____
PIP ADDRESS _____
PIP ADJUSTER _____ PIP PHONE # _____
PIP CLAIM # _____

INJURIES/TREATMENT/LOST WAGE INFORMATION

INJURIES _____
HOSPITAL _____
FAMILY PHYSICIAN _____
OTHER TREATING PHYSICIANS/FACILITIES _____
DO YOU HAVE ANY PHOTOGRAPHS OF YOUR INJURIES? YES ___ NO ___
LOST TIME FROM WORK? YES ___ NO ___ If Yes, dates missed _____
EARNINGS _____
OTHER MEDICAL INSURANCE _____

OPPOSING DRIVER INFORMATION

DRIVER'S NAME: _____ HOME PHONE _____
ADDRESS: _____ WORK PHONE _____
_____ ZIP CODE: _____
DRIVER'S LICENSE #: _____ STATE ISSUED _____
YEAR AND MAKE OF VEHICLE: _____ TAG # _____
DESCRIBE ANY PROPERTY DAMAGE TO VEHICLE _____
OWNER'S NAME: _____ HOME PHONE _____
ADDRESS: _____ WORK PHONE _____
_____ ZIP CODE _____
WERE THERE ANY PASSENGERS IN THE STRIKING VEHICLE? YES ___ NO ___ If Yes, please list their
names, addresses and phone numbers: _____
INSURANCE COMPANY: _____ POLICY # _____
HAVE YOU HAD ANY CONTACT WITH THE INSURANCE COMPANY? YES ___ NO ___ If Yes, provide contact
name and claim number, if applicable, and brief description of your conversations: _____

PRIOR INJURIES/CLAIMS

HAVE YOU EVER BEEN INVOLVED IN ANY OTHER ACCIDENTS? YES ___ NO ___
PRIOR CLAIMS/INJURIES _____

LIST PRIOR ATTORNEYS WHO REPRESENTED YOU IN THIS MATTER: _____

REFERRED BY: _____