CLIENT INFORMATION REPORT-PERSONAL INJURY

(Confidential)

Clients frequently have a great deal of valuable information concerning how and why their injury occurred and who was at fault. Good lawyers should be aware of this and listen to their clients. Please help me help you by answering all of the following questions in as much detail as you can. Any problem important enough to see a lawyer is important enough to complete this form.

Write clearly, and only on the printed side of these pages. If more writing space is needed, attach other paper, identify each answer by question number, and write on one side of the page only. **If this form is not complete your appointment may be subject to being rescheduled.**

Date: ______________________________

Injured Party: Name :____

Street Address or P.O. Box: ______________________________________

City: __________________ State: ____________ Zip code: _________________

Telephone number: H: (________)______________________________

W: (________)______________________________

C: (________)______________________________

E-mail address: ______________________________

Social Security No. : ______________ ________ ________________

Date of Birth :________________________________

Age: ______________________________________

Employer's Name:____

Address : ____

Telephone: (_______) ____

Due to Section 111 Mandatory Medicare/Medicaid Reporting Requirements:

Are you a Medicaid recipient? YES NO

Are you a Medicare recipient (or will be within the next 30 months)? YES NO

If so, please provide your Medicare/Medicaid number: __________________________

Emergency Contact Information (Please include the name, relationship, address and phone number)

Name: ______________________________ Relationship __________________

Street Address or P.O. Box: ______________________________________

City: ____________________ State: _______________ Zip code: __________

Telephone number: (_______)________________________

If Minor: Father's Name:____

Address:____

Telephone: (________) ____

Mother's Name:____

Address:____

Telephone: (________) ____

Custody with: Father ______________________ Mother _________________________

Other: ____

How were you referred to our office?

Turner Law Offices Website ☐ Internet ☐ Injury Helpline ☐

Phone book, which one? Yellowbook ☐ Superpages ☐

Attorney ☐ Name: _________________________ Family member/Friend ☐ Name _________________________

Other ____________________________________

1. Injury:

Date of Injury:____

Time of Day: ____

Day of Week:____

Location:____

Weather Conditions:____

ATTORNEY'S USE ONLY **Statute of Limitations** ____ ____

2. Person (s) Who Caused Your Injury:

a. Name ____

Address ____

Name and address of Employer (if known) ____

____

b. Name ____

Address ____

Name and address of Employer (if known) ____

____

c. Name ____

Address ____

Name and address of Employer (if known) ____

____

d. Name ____

Address ____

Name and address of Employer (if known) ____

____

3. Witnesses to Accident:

a. Name ____

Address ____

____

Telephone Number (_______) ____

b. Name ____

Address ____

____

Telephone Number (_______) ____

c. Name ____

Address ____

____

Telephone Number (_______) ____

d. Name ____

Address ____

____

Telephone Number (________) ____

4. General Description of What Happened:____

____

____

____

If appropriate, please draw diagram of the scene of the occurrence:

5. Accident Reports: Was Accident Reported?

To Whom? ____

When? ____

List every entity which might have investigated the incident, including local police, sheriff's office, state troopers, insurance company, etc., including name of investigating officer, if known

____

____

____

____

Were any criminal or other charges filed as a result of the incident? ____________________________

____

What was the result of the case? ____

____

____

6. Were any photographs taken of the scene, vehicles involved, persons injured, product involved, etc.?

____

____

If so, please describe what photographs were taken, by whom they were taken, and who has current possession of the photographs. ____

____

____

____

7. Your Insurance: Name of Company ____

Address ____

____

Name of Agent ____

Any reports to them? ____

When? ____

What was contained in the report? ____

____

____

____

8. History: Single ____________________ Married ____________________

Spouse's Name ____

Prior Marriages? ____

Former Spouses' Names ____

____

How ended: Divorce ________ Date: ______________________________

Annulment ______ Date: ______________________________

Death __________ Date: ______________________________

9. Children:

Name:____

Age ____________ Claimed as Dependent? ______________________________

Address:____

Telephone No. (________) ____

Name:____

Age _____________ Claimed as Dependent? ____

Address:____

Telephone No.: (_________) ____

Name:____

Age:_____________ Claimed as Dependent? ____

Address: ____

Telephone No.: (_________) ____

Name: ____

Age:_____________ Claimed as Dependent? ____

Address: ____

Telephone No.: (_________) ____

10. Other Dependents:

Name: ____

Age:___________ Relationship :____

Address:____

Telephone No.: (_________) ____

Name: ____

Age:___________ Relationship: ____

Address: ____

Telephone No.: (_________) ____

Name:____

Age:___________ Relationship: ____

Address: ____

Telephone No.: (_________) ____

11. Your Educational Background and Vocational Training ____

____

____

12. Employment: Position ____

Date Employed ____

Rate of Pay _____________ Gross _____________ Net ______________

Dates lost from work because of this injury:

From ___________________________ to _________________________________

Total Amount of Wages Lost ____

Did you receive any short term or long term disability benefits during your time off work? Yes____ No_____

If so, please identify the name and address from which insurance company such benefits were received:

____

____

____

13. Prior Work Record:

a. Name of Employer ____

Address of Employer ____

Dates of Employment ____

Type of Work ____

Wages ____

Reason for Leaving ____

____

b. Name of Employer ____

Address of Employer ____

Dates of Employment ____

Type of Work ____

Wages ____

Reason for Leaving ____

c. Name of Employer ____

Address of Employer ____

Dates of Employment ____

Type of Work ____

Wages:____

Reason for Leaving ____

14. Any Damage Other Than Personal Injury (including Car, if a Vehicle Case): ___________________________

____

____

____

15. Medical (This Injury): (PLEASE COMPLETE THE ATTACHED HEALTH CARE PROVIDER INFORMATION SHEET)

Type of Injury (Describe fully the condition) ____

____

____

16. Any Insurance or Compensation Benefits Paid?_____________ By Whom?_____________________________

For What? ____

Dates _____________________________ Amounts ____

17. If Case Involves Auto Accident, Complete the Following:

Plaintiff (Your) Vehicle Info: Make __________________Model __________________ Year ____________

Color __________________ Registered Owner ____

Address ____

____

Occupation ____

Legal Owner ____ Age____________

Address ____

____

Automobile Insurance Policy Company ____

Agent ____

Who was driving? Name____

Age _____________ Address ____

____

Damage to Vehicle ____

Repaired? _______________ Date _____________________ Cost_____________________________________

Seat Belts Used? ____

18. Defendant Vehicle Info: Make _________________________Model_____________________ Year ________

Color ___________________ Registered Owner ____

Address ____

Occupation ____

Who was driving? Name____

Age ______________ Address ____

____

Occupation ____

19. Defendant's Insurance (If Known)* Please fill out whether or not the case deals specifically with automobile accidents.

Name of Company ____

Address ____

____

Name, address, telephone number and employer of adjusters or insurance representative handling file, if known: ____

____

____

Any Reports to Them? _________________________ When (Date)? __________________________________

20. List all accidents in the past ten (10) years causing injury to you: _____________________________________

____

____

____

21. List all lawsuits in which you were a party: ____

____

____

22. List all hospitalizations for the past ten (10) years:

a. Hospital ____

Date ____________ Reason ________________________________

____

b. Hospital ____

Date ______________ Reason ______________________________

____

c. Hospital ____

Date __________ Reason __________________________________

____

23. List all **major** illness in life: ______________________________________

____

____

____

____

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FOR ATTORNEY'S USE ONLY

Statute of Limitations: ____________________ Docketed ___________________________

Medical Authorizations signed ___________________________

Additional instructions:____

____

____

Health Care Provider Information Sheet

*** ATTENTION ***

It is the client's responsibility to keep TURNER & SACKETT updated throughout the pendency of the case of any and all medical treatment and related medical bills associated with his/her claim. Any unknown medical bill(s)/liens/subrogations or any medical bill(s)/liens/subrogations provided after the conclusion of the case *WILL BE THE RESPONSIBILITY OF THE CLIENT.*

For Office Use Only:
DOA: ______________________
Injured Party: _______________________________

Group Health Insurance Carrier: ____
Policy Number: ____
Insured: ____
Primary Care Provider's Name, Address and Phone Number_____________________________________
____

Please complete the information listed below for all physicians, hospitals, chiropractors, dentists, and oral surgeons, or any other medical provider who has treated you due to this accident.

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ___________________ No: ____________________ Unknown: ____________________