

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: (_____) _____ May we text you? Y N

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: _____

=====

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: _____