FARHA
ATTORNEY AT LAW

Personal Injury Intake Form

I. Client Information:

Date: ______________________

Full Legal Name: ______________________

Address, City , State , Zip: ______________________

E-mail: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Work Phone: ______________________

II. Personal Information:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse's Name/Significant Other: ______________________

Children/Names/Ages: ______________________

Drivers License Number: ______________________

Date of Birth: ______________________

Referred by: ______________________

Social Security Number: ______________________

Name of Emergency Contact: ______________________

Relationship: ______________________

Emergency Contact Information: ______________________

II. Personal Information Continued:

Prior Criminal Record ☐?Yes ☐ No

Explain: ______

Prior Traffic Citations ☐?Yes ☐ No

Explain: ______

Do You Use Social Media ☐?Yes ☐ No

List and and all, i.e. Facebook, Twitter, etc.: ______

III. Accident Information:

Date of Accident: ______

Statue of Limitations: ______

Time Of Accident: ______

Location: ______

How did the accident happen?

______

Passengers in vehicle? ______

Investigated by Police? ☐ Yes ☐ No

Accident Report Obtained? ☐ Yes ☐ No

Incident Number: ______

Statements given to anyone ☐ Yes ☐ No

To whom? ______

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III. Accident Information Continued:

Tickets or Citations Issued? ☐ Yes ☐ No

To Which Party? ______________________________

Ticket or Citation Number: ______________________________

IV. Injuries:

Injuries Sustained in this Accident: ______________________________

Prior Injuries: ______________________________

Pre-Existing Conditions: ______________________________

Medical Conditions/Diseases: ______________________________

V. Client's Insurance Information:

Insurance Company: ______________________________

Agent's Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

E-Mail ______________________________

Policy Number: ______________________________

Claim Number: ______________________________

Liability Coverage: ☐ Yes ☐ No If so , how much? __________

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V. Client's Insurance Information Continued:

Under/Uninsured Coverage: ☐ Yes ☐ No If so, how much? ____________

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? ____________

Collision: ☐ Yes ☐ No If so, how much? ____________

Rental: ☐ Yes ☐ No If so, how much? ____________

Claims Adjuster: ____________

Address: ____________

Phone Number: ____________

Fax Number: ____________

E-Mail ____________

Med-Pay Adjuster: ____________

Address: ____________

Phone Number: ____________

Fax Number: ____________

E-Mail: ____________

VI. Client's Insurance Information 2:

(Please complete for each insurance policy (commercial or personal) which insures any vehicle owned by you or anyone in your household.)

Insurance Company: ____________

Agent's Name: ____________

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Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

E-Mail ______________________________

Policy Number: ______________________________

Claim Number: ______________________________

Liability Coverage: ☐ Yes ☐ No If so , how much? __________

Under/Uninsured Coverage: ☐ Yes ☐ No If so, how much? __________

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? __________

Collision: ☐ Yes ☐ No If so, how much? __________

Rental: ☐ Yes ☐ No If so, how much? __________

Claims Adjuster: ______________________________

Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

E-Mail ______________________________

Med-Pay Adjuster: ______________________________

Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

VI. Client's Insurance Information 2 Continued:

E-Mail: ____________________

VII. Client's Vehicle Information:

Year: ____________________

Make: ____________________

Model: ____________________

Color: ____________________

Mileage and General Vehicle Information: ____________________

Name of Towing Company: ____________________

Do you Own Any Other Vehicles? (Car, Truck, RV, Motorcycle) ☐ Yes ☐ No

If you answered yes, please provide the following information for each vehicle:

Insurance Information:

Insurance Company: ____________________

Agent's Name: ____________________

Address: ____________________

Phone Number: ____________________

Fax Number: ____________________

E-Mail ____________________

Policy Number: ____________________

Claim Number: ____________________

Liability Coverage: ☐ Yes ☐ No If so , how much? __________

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VII. Clients Vehicle Information Continued.

Under/Uninsured Coverage: ☐ Yes ☐ No — If so, how much? ________

Medical Payment/Med-Pay: ☐ Yes ☐ No — If so, how much? ____

Collision: ☐ Yes ☐ No — If so, how much? ________

Rental: ☐ Yes ☐ No — If so, how much? ________

Does a Family Member in Your Household own a Vehicle? ☐ Yes ☐ No

If you answered yes, please provide the following information for each vehicle:

Insurance Information:

Insurance Company: ____________________

Agent's Name: ____________________

Address: ____________________

Phone Number: ____________________

Fax Number: ____________________

E-Mail ____________________

Policy Number: ____________________

Claim Number: ____________________

Liability Coverage: ☐ Yes ☐ No — If so , how much? ________

Under/Uninsured Coverage: ☐ Yes ☐ No — If so, how much? ________

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VII. Client's Vehicle Information Continued:

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? __________

Collision: ☐ Yes ☐ No If so, how much? __________

Rental: ☐ Yes ☐ No If so, how much? __________

VIII. Client's Health Insurance Information:

Name of Insured: __________

Insurance Company __________

Address: __________

Phone: __________

Policy Number: __________

Group Number: __________

Identification Number: __________

Type of Coverage: __________

Medicare: ☐ Yes ☐ No

Medicare Number: __________

Medicaid ☐ Yes ☐ No

Medicaid Number: __________

IX. Medical Treatment Information:

(Please list all doctors including Ambulance and ER visits since the date of the accident)

Ambulance? ☐ Yes ☐ No

Name of Ambulance Service: __________

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IX. Medical Treatment Information Continued:

Do You have Copies of Medical Bills and Records? ☐ Yes ☐ No

Emergency Room? ☐ Yes ☐ No

Name of Emergency Room? ______________________

Who has paid your medical bills? ______________________

Medical Providers (Doctors, Physical Therapy, Chiropractor, MRI, etc...):

Medical Facility 1: ______________________

Treating Physician /Physical Therapist/ Chiropractor: ______________________

Dates of Service: ______________________

Facility Address: ______________________

Phone Number: ______________________

Fax Number: ______________________

E-mail: ______________________

Medical Facility 2: ______________________

Treating Physician /Physical Therapist/ Chiropractor: ______________________

Dates of Service: ______________________

Facility Address: ______________________

Phone Number: ______________________

Fax Number: ______________________

E-mail: ______________________

Medical Facility 3: ______________________

Treating Physician /Physical Therapist/ Chiropractor: ______________________

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IX. Medical Treatment Information Continued:

Dates of Service: ______________________________

Facility Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

E-mail: ______________________________

Medical Facility 4: ______________________________

Treating Physician /Physical Therapist/ Chiropractor: ______________________________

Dates of Service: ______________________________

Facility Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

E-mail: ______________________________

Medical Facility 5: ______________________________

Treating Physician /Physical Therapist/ Chiropractor: ______________________________

Dates of Service: ______________________________

Facility Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

E-mail: ______________________________

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X. Property Damage Information:

Property Damage Already Collected on Your Vehicle? ☐ Yes ☐ No

Property Damage Amount ________

Do You have and Estimate for Property Damage? ☐ Yes ☐ No

Do You have Pictures of Your Vehicle? ☐ Yes ☐ No

Estimate Amount ________

XI. Lost Wages:

Did you Miss Work as a Result of this Accident? ☐ Yes ☐ No

Employer: ________

Contact Name & Phone Number: ________

If so, who can verify your lost wages? ________

Rate of Pay: ________

Paid how Often? ________

XII. Defendant's Insurance Information:

Is there more than one defendant? If so, please enter all of the following information for each defendant. ☐ Yes ☐ No

Defendant 1

Defendant's Insurance Company: ________

Policy Number: ________

Claim Number: ________

Full Legal Name: ________

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XII. Defendant's Insurance Information Continued:

Address, City , State , Zip: ________________

E-mail: ________________

Home Phone: ________________

Cell Phone: ________________

Work Phone: ________________

Drivers License Number: ________________

Date of Birth: ________________

Social Security Number: ________________

Name of Owner of Vehicle: (if different from driver) ________________

Relationship Between Driver and Owner:

- ☐ Employer-Employee
- ☐ Parent-Child
- ☐ Family
- ☐ Friend
- ☐ Other

Bodily Injury Adjuster's Name: ________________

Address: ________________

Phone Number: ________________

Fax Number: ________________

E-Mail: ________________

Property Adjuster's Name: ________________

Address: ________________

Phone Number: ________________

Fax Number: ________________

E-Mail: ________________

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XII. Defendant's Insurance Information Continued:

Any Additional Notes or Information: ______________________

Defendant 2

Defendant's Insurance Company: ______________________

Policy Number: ______________________

Claim Number: ______________________

Full Legal Name: ______________________

Address, City , State , Zip: ______________________

E-mail: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Work Phone: ______________________

Drivers License Number: ______________________

Date of Birth: ______________________

Social Security Number: ______________________

Name of Owner of Vehicle: (if different from driver) ______________________

Relationship Between Driver and Owner:

- ☐ Employer-Employee
- ☐ Parent-Child
- ☐ Family
- ☐ Friend
- ☐ Other

Bodily Injury Adjuster's Name: ______________________

Address: ______________________

Phone Number: ______________________

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XII. Defendant's Insurance Information Continued:

Fax Number: ______________________

E-Mail: ______________________

Property Adjuster's Name: ______________________

Address: ______________________

Phone Number: ______________________

Fax Number: ______________________

E-Mail: ______________________

Any Additional Notes or Information: ______________________

Other Important Information and Notes: ______________________

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Copies to Bring with You

- ○ Drivers License
- ○ Health Insurance Card
- ○ Auto Insurance Card
- ○ Declarations Sheet
- ○ Medical Records
- ○ Medical Bills
- ○ Photographs of Client Vehicle
- ○ Photographs of Defendant Vehicle
- ○ Photographs of Injuries

Disclaimer: The submission of information does NOT establish an attorney-client relationship. This form is for case evaluation purposes. Please contact attorney's office. if you would like to discuss hiring/retaining an attorney.

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