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Date of Incident: ___________________

Limitations Run: ___________________

Date of Interview: __________________

CLIENT INFORMATION

How did you hear of us? ____

DATE OF ACCIDENT/INCIDENT _______________

FULL NAME: (including maiden)____

MAILING ADDRESS:____

CITY, STATE, ZIP & COUNTY:____

HOME PHONE:____________________

PAGER:_____________________________

WORK PHONE:___________________

CELLULAR:________________________

Social Security Number: ________ - ______ - ________

EMAIL: __________________________ **How often do you check it?** ____________

Texas (or valid) Drivers License Number:_______________

Date of Birth: _________________

YOUR OWN INSURANCE (AUTO) COVERAGE *(AT TIME OF WRECK)*

NAME OF INS. CO.:____

Do you have FULL COVERAGE?

UNDERINSURED __________

UNINSURED __________

PIP (Personal Injury Protection) _________

(PLEASE NOTE THAT FULL COVERAGE IS NOT JUST 'LIABILITY' INSURANCE)

YOUR POLICY NO.:________________
YOUR CLAIM NO.:_______________________
YOUR INSURANCE COMPANY'S PHONE# _____________________________
POLICY LIMITS: $____________________ per person

THE PERSON THAT HIT YOU (CAUSED THE WRECK)

NAME OF THE PERSON THAT HIT YOU: __________________________________

ADDRESS OF THE PERSON THAT HIT YOU: _______________________________
____
____

NAME OF INSURANCE COMPANY OF THE PERSON THAT HIT YOU:
____

DEFENDANT'S POLICY NO.:________________
DEFENDANT'S CLAIM NO.:_______________________
INSURANCE COMPANY'S PHONE# _____________________________
ADJUSTER HANDLING CLAIM: ________________________________

YOUR MEDICAL INFORMATION *(AT TIME OF WRECK)*

ARE YOU ON MEDICAID OR MEDICARE?

IF SO, PLEASE LIST THE IDENTIFICATION NO.

MEDICARE#: ___________________________________

MEDICAID#: ___________________________________

DO YOU HAVE PRIVATE INSURANCE?

IF SO, PLEASE LIST THE FOLLOWING:

HEALTH CARE PLAN NAME: _____________________

Account #: _______________________________________

Group #: _________________________

PHONE NUMBER OF PLAN: ______________________

DO YOU OWE ANY BACK CHILD SUPPORT?

Yes: __________ If so, how much? $ _______________

No: ___________

DID YOU VISIT THE HOSPITAL?… If so…

NAME OF HOSPITAL: ____

ADDRESS:____

CITY, STATE, ZIP:__________________________

PHONE NO.: ________________________________

TAKEN BY AMBULANCE: ______________

DATE ADMITTED: ______________________ DATE DISCHARGED: __________

DID YOU VISIT THE DOCTOR? If so…

NAME OF DOCTOR: ____

ADDRESS:____

CITY, STATE, ZIP:___________________________ **PHONE NO.:** ______________

DATE SEEN:______________________

DOCTOR:____

ADDRESS:____

CITY, STATE, ZIP:___________________________ **PHONE NO.:** ______________

DATE SEEN:______________________

PLEASE LIST ANY ADDITIONAL MEDICAL PROVIDERS YOU HAVE SEEN: (I.E., THERAPY, REHABILITATION, ETC.)

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FACTS OF THE ACCIDENT

DATE OF ACCIDENT/INCIDENT: ______________________

TIME OF ACCIDENT: ____________________________________

LOCATION OF ACCIDENT/INCIDENT (PLEASE INCLUDE STREETS, INTERSECTIONS, CITY, COUNTY AND STATE): _________________________

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WHICH POLICE AGENCY INVESTIGATED, IF ANY: _____________________

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DESCRIPTION OF ACCIDENT/INCIDENT: _______________________________

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DESCRIBE ALL YOUR INJURIES:

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EMPLOYMENT HISTORY

CURRENT NAME OF EMPLOYER:____

ADDRESS:____

CITY, STATE, ZIP/PHONE:____

NAME OF EMPLOYER AT TIME OF ACCIDENT:___________________________

ADDRESS:____

CITY, STATE, ZIP:____

EMPLOYED FROM:_________ **TO:**___________

JOB TITLE/DUTIES:____

SUPERVISOR:______________**EARNINGS/WAGE RATE:** _________________

TIME LOST SINCE ACCIDENT:____

THE NAME, ADDRESS AND PHONE NUMBER OF SOMEONE WHO WILL ALWAYS BE ABLE TO GET IN TOUCH WITH YOU:______________________

____

MISCELLANEOUS INFORMATION

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE CLASSIFIED AS A FELONY OR MISDEMEANOR? IF SO, PLEASE STATE THE NATURE OF EACH CONVICTION, THE COUNTY, STATE AND COURT OF EACH CONVICTION, AND THE DATE AND/OR DATES FOR EACH CONVICTION:____

____

____

DO YOU HAVE PICTURES OF CAR??? ___________

<<<PLEASE FORWARD ALL PHOTOS OF YOUR DAMAGES TO LAW FIRM>>>

ARE THERE ANY WITNESSES??? _______________

***IF YES…* PLEASE LIST NAMES AND CONTACT INFORMATION OF THE WITNESSES:**

NAME: _________________________________ TEL #: ___________________

NAME: ________________________________ TEL#: ____________________

NAME: _________________________________ TEL #: ___________________

NAME: ________________________________ TEL#: ____________________

MINOR CHILD/CHILDREN
(*Only if child involved in accident*)

CHILD'S NAME:____

DOB:___________________________ **SSN:**________________________________

CUSTODY WITH: ____

FATHER'S NAME:____

ADDRESS:____

CITY, STATE, ZIP:____

HOME PHONE:____________________ **PAGER:**______________________

WORK PHONE:____________________ **CELLULAR:**_______________________

SSN:___________ **TDL:**____________________ **DOB:** __________________

MOTHER'S NAME:____

ADDRESS:____

CITY, STATE, ZIP:____

HOME PHONE:____________________ **PAGER:**______________________

WORK PHONE:____________________ **CELLULAR:**_______________________

SSN:______________ **TDL:**________________ **DOB:** __________________