GREGG S. HARRISON
Attorney at Law, PLLC

Office: 281.929.0110
Cell: 832.797.7600
Fax: 281.304.7676

One Greenway Plaza
Suite 100
Houston, Texas 77046

gregg@greggharrison.com

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: _____

THE PLACE WHERE YOU WERE HURT

NAME OF THE ESTABLISHMENT: _____

ADDRESS OF THE ESTABLISHMENT: _____

_____

_____

NAME OF INSURANCE COMPANY:

_____

DEFENDANT'S POLICY NO.:_____
DEFENDANT'S CLAIM NO.:_____
INSURANCE COMPANY'S PHONE# _____
ADJUSTER HANDLING CLAIM: _____

YOUR MEDICAL INFORMATION *(AT TIME OF FALL/INCIDENT)*

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: _____

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.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FACTS OF THE ACCIDENT

DATE OF ACCIDENT/INCIDENT: _____

TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT/INCIDENT (PLEASE INCLUDE LOCATION OF STORE, WHAT PART OF STORE YOU WERE IN, etc.): (What exactly happened??):

_____

_____

_____

_____

WHICH POLICE AGENCY INVESTIGATED, IF ANY: _____

_____

_____

DESCRIPTION OF ACCIDENT/INCIDENT: _____

_____

_____

_____

_____

_____

_____

_____

<u>Why do you believe the establishment is at fault for your fall and injuries</u>?:

_____

_____

_____

_____

DID YOU GET/TAKE ANY PHOTOGRAPHS of the area or your injuries???

_____

If so… please provide any pictures to the attorney with your completed paperwork or email them.

DID YOU REPORT THE INCIDENT TO THE STORE/ESTABLISHMENT/OWNER? _____

IF SO, WAS A REPORT TAKEN? _____

DID YOU GIVE A STATEMENT OF ANY KIND? _____
IF SO, WHAT DID YOU STATE and to WHOM?

_____

_____

_____

_____

_____

_____

_____

_____

_____

DID YOU GET A COPY OF THE REPORT? _____

IF SO…. MY FIRM NEEDS A COPY OF THE REPORT!

DESCRIBE ALL YOUR INJURIES:

_____

_____

_____

_____

_____

_____

_____

YOUR 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:_____

_____

_____

ARE THERE ANY WITNESSES??? _____

If so.. we needs names and contact information:

_____

_____

_____

_____

_____