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For Law Firm:
Date of Incident: _____
Date of Interview: _____
SOL: _____

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 NAME OF THE PRODUCT THAT HURT YOU

NAME OF THE PRODUCT: _____

BUSINESS/ADDRESS WHERE ITEM WAS PURCHASED:

_____
_____
_____
_____

Any warnings on the package/item?? _____

_____

_____

*****IMPORTANT******

********PLEASE RETAIN ANY AND ALL ITEMS/PACKAGING/RECEIPTS THAT ARE RELATED TO THIS CLAIM!********

NAME OF INSURANCE COMPANY FOR ESTABLISHMENT: (If known)

_____

DEFENDANT'S POLICY NO.:_____

DEFENDANT'S CLAIM NO.:_____

INSURANCE COMPANY'S PHONE# _____

ADJUSTER HANDLING CLAIM: _____

DID YOU PERSONALLY PUT THE ESTABLISHMENT ON NOTICE OF YOUR CLAIM:?? _____

IF SO…HOW/WHEN?? _____

_____

_____

_____

If you wrote any sort of letter to the establishment (which is highly DISCOURAGED WITHOUT AN ATTORNEY) – please copy the letter and provide to my firm for review).

YOUR MEDICAL INFORMATION *(FOR THIS 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/EMERGENCY ROOM?...

If so…

NAME OF HOSPITAL: _____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE NO.: _____

TAKEN BY AMBULANCE?: _____

DATE ADMITTED: _____ DATE DISCHARGED: _____

DID YOU VISIT ANY DOCTOR(s)? If so…

NAME OF DOCTOR: _____

ADDRESS:_____

CITY, STATE, ZIP:_____ PHONE NO.: _____

DATE SEEN:_____

DOCTOR:_____

ADDRESS:_____

CITY, STATE, ZIP:_____ PHONE NO.: _____

DATE SEEN:_____

NAME OF 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: _____

ANY AGENCY INVESTIGATED?: _____

_____

_____

DESCRIPTION OF ACCIDENT/INCIDENT: (Describe what happened in detail please)….

_____

_____

_____

_____

_____

_____

DESCRIBE ALL YOUR INJURIES/PAIN/Etc:

_____

_____

_____

_____

_____

_____

_____

_____

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/Photos/Videos??? _____

If so… please provide copies to the attorney.

ARE THERE ANY WITNESSES??? _____

ANY ONE ELSE INJURED AS A RESULT OF THIS INCIDENT?? _____

****IMPORTANT******

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