GREGG S. HARRISON
Attorney At Law PLLC

For Office Use Only

Date of Incident: _____

Limitations Run: _____

Date of Interview: _____

AUTO ACCIDENT CLIENT FORM

Client Information

Date of accident/incident:			
Full name (including maiden name):			
Street address:			
City:	State:	Zip:	County:
Home phone:		Work phone:	
Cell phone:		Pager:	
Email:			
How often do you check email:			
Social security number: _____ - ___ - _____			
Texas (or valid) drivers license number:			
Date of birth:			
How did you hear about our firm? ❒ Google ❒ Facebook ❒ Friend ❒ Other			

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Your Own Auto Insurance Coverage (at time of wreck)

Name of insurance company:
Do you have any of the following? *(please note that full coverage is not just "liability" insurance)* Underinsured motorist coverage: ❒ Yes ❒ No Uninsured motorist coverage: ❒ Yes ❒ No Personal injury protection (PIP): ❒ Yes ❒ No
Your policy no.:
Your claim no.:
Your insurance company's phone:
Policy limits: $_____ per person

The Person Who Hit You/Caused the Wreck

Full name of the person who hit you:			
Street address of the person who hit you:			
City:	State:	Zip:	County:
Name of his/her insurance company:			
Your claim no.:			
Your insurance company's phone:			
Defendant's policy no.:			
Defendant's claim no.:			
Insurance company's phone:			
Adjuster handling claim:			

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Your Medical Information at Time of Wreck

Are you on Medicaid or Medicare? ❒ Yes ❒ No If yes, please list the identification number: Medicare #: _____ Medicaid #: _____			
Do you have private insurance? ❒ Yes ❒ No If yes, please list the following: Health Care Plan Name: _____ Account #: _____ Group #: _____ Phone Number of Plan: _____			
Do you owe any back child support? ❒ Yes ❒ No If yes, please provide the amount owed: $_____			
Did you visit the hospital? ❒ Yes ❒ No If yes, please provide the following information:			
Name of hospital:			
Street address:			
City:	State:	Zip:	County:
Phone number:			
Were you taken by ambulance? ❒ Yes ❒ No If yes: Date admitted: _____ Date discharged: _____			

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Your Medical Information at Time of Wreck (continued)

Did you visit the doctor? ❒ Yes ❒ No If yes, what is the name of the doctor: _____			
Street address:			
City:	State:	Zip:	County:
Phone number:			
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/incident:
Location of accident/incident (please include streets, intersections, city, county and state.):
Which police agency investigated, if any:

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Facts of the Accident (continued)

Description of accident/incident:
Please describe all of your injuries:
Did you get/take any photographs of the scene, property damage, etc.? ❒ Yes ❒ No If yes, please provide any pictures with your completed paperwork or email them to gregg@greggharrison.com.
Did you give a statement of any kind? ❒ Yes ❒ No If so, what did you state and to whom?
Did you get a copy of the report? ❒ Yes ❒ No If so, my firm needs a copy of the report. Please include it with your completed form.

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Your Employment History

Name of current employer:			
Street address:			
City:	State:	Zip:	County:
Phone:		Email:	
Name of employer at time of accident:			
Street address:			
City:	State:	Zip:	County:
Phone:		Email:	
Employment dates: From _____ to _____			
Job title/duties:			
Supervisor:			
Earnings/wage rate:			
Time lost since accident:			
Contact information for someone who will always be able to get in touch with you: Street address:			
City:	State:	Zip:	County:
Phone:		Email:	

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Miscellaneous Information

Have you ever been convicted of a criminal offense classified as a felony or misdemeanor?
❒ Yes ❒ No

If yes, 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? ❒ Yes ❒ No
If yes, please provide their names and contact information:

Is there anything else you would like to share about your incident: ❒ Yes ❒ No

If yes, please use the space below to elaborate:

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Minor Child/Children (only if involved in accident)

Child's full name:			
Date of birth:			
Social security number: _____ - ___ - _____			
Custody with: ❒ Mother ❒ Father ❒ Other: _____			
Father's full name:			
Street address:			
City:	State:	Zip:	County:
Home phone:		Work phone:	
Cell phone:		Pager:	
Email:			
Social security number: _____ - ___ - _____		Date of birth:	
Texas (or valid) drivers license number:			
Mother's full name:			
Street address:			
City:	State:	Zip:	County:
Home phone:		Work phone:	
Cell phone:		Pager:	
Email:			
Social security number: _____ - ___ - _____		Date of birth:	
Texas (or valid) drivers license number:			