CLIENT DATA SHEET

DATE: _____

FULL NAME: _____

ADDRESS _____

_____

HOME PHONE: _____ CELL PHONE _____

HEIGHT: _____ WEIGHT _____ LEFT/RIGHT HANDED_____

HEALTH INSURANCE CO: _____ MEDICAID? Y/N_____

MARITAL STATUS: MARRIED ( ) SINGLE ( )

DATE OF BIRTH _____

SOCIAL SECURITY #: _____

EMPLOYER: _____

ADDRESS: _____

EMAIL ADDRESS: _____

BUSINESS PHONE #: _____

EMERGENCY CONTACT PERSON: _____

ADDRESS _____

_____

PHONE #: _____

TYPE OF CASE: _____

REFERRED BY:
( ) PHONE BOOK ( ) ADVERTISEMENT ( ) FORMER CLIENT ( ) OTHER

TO BE COMPLETED BY LAW OFFICE

Defendant Ins. Co: _____ ADJUSTER _____

Claim No: _____

Plaintiff Insurance Co. _____ Limits: _____

No. Cars Insured: _____ UM: ( )Yes ( ) No Limits _____

Medical Payments: ( ) Yes ( ) No DOA _____

Declaration Page on File: ( ) Yes ( ) No

Defendant Name: _____

Defendant Vehicle Type: _____

Plaintiff Vehicle Type: _____

Vehicle Repair Costs: _____TOTALED? ( ) Yes ( ) No _____

Salvage Location: (If Applicable): _____

City, County, State of Accident: _____

Type: ( ) Rear-Ended ( ) Head-on ( ) Other

Statue of Limitations: _____ Limits: _____

Accident Report on File: ( ) Yes ( ) No ( ) Pending

Witness ( ) Yes ( ) No Name & Number _____

Other Victims: _____

Plaintiff's Injuries: _____

_____

Transported by: _____ Emergency Room: _____
RX: ( ) Yes, ( ) No _____
Main Treating Doctor: _____
Referred for Treatment @ _____
Previous Similar Accident ( ) Yes, ( ) No Similar Injury ( ) Yes ( ) No