ROBERSON LAW FIRM PLLC

ATTORNEY-CLIENT COMMUNICATION: THIS DOCUMENT AND ITS CONTENTS CONSTITUTE LEGALLY PRIVILEDGED INFORMATION

PERSONAL INJURY CLIENT INFORMATION FORM

TODAY'S DATE: _____

INJURED PARTY'S PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Fax: _____ Email: _____

SSN: _____ Driver's License: _____ State: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Spouse: _____ Children? (circle one) Yes No

Language Preference (circle one) English Spanish

Please list at least two relatives not living with you through whom we may contact you:

Contact 1: Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

Contact 2: Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

How did you hear about this law firm? _____

ACCIDENT INFORMATION

Description of Accident: _____

_____

_____

_____

_____

_____

_____

_____

Date of Accident: _____ Time of Accident: _____

Street Location: _____

City: _____ County: _____ State: _____

Photos taken? (circle one) Yes No
Accident report filed? (circle one) Yes No
Name of investigating police department: _____

Any passengers in your vehicle? (circle one) Yes No If so, how many? _____

Passenger 1:
Name: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Passenger 2:
Name: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Passenger 3:
Name: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Passenger 4:
Name: _____

Address: _____

City: _____

State/Zip: _____

Phone: _____

Was the injured party the driver? (circle one) Yes No

If not, where was injured party seated in vehicle? _____

INJURED PARTY'S VEHICLE INFORMATION

Where is your vehicle located? _____

Vehicle Year _____ Vehicle Make _____ Vehicle Model _____

Area of damage _____ Amount of damage _____

Has property damage been paid? (circle one) Yes No If so, by whom? _____

Who is the owner of the vehicle? _____ Lienholder?_____

If not, did you have permission to use the vehicle? (circle one) Yes No

Relationship to the owner of vehicle: _____

Did you receive a ticket? (circle one) Yes No

If yes, for what reason? _____

To the best of your knowledge, was anyone cited for DWI or DUI? (circle one) Yes No

INJURED PARTY'S AUTO INSURANCE INFORMATION

Company: _____

Address: _____

City/State/Zip: _____

Policy No.: _____

Phone: _____

Fax: _____

Please circle all types of coverage on your auto insurance policy.
Liability Collision PIP Uninsured/Underinsured Motorist

Have you contacted your insurance company about this accident? (circle one) Yes No

If so, was a claim established? (circle one) Yes No

Claim No.: _____ Adjuster: _____

Did you give a statement to your insurance company? (circle one) Yes No

If so, to whom? _____

INJURED PARTY'S EMPLOYMENT INFORMATION

Employer: _____

Address: _____

City/State/Zip _____ Phone:_____

Years employed: _____ Position title: _____

Supervisor's name: _____ Phone: _____

Salary: _____ Hourly _____ Weekly _____ Semi-monthly _____ Annually

Were you on the job at the time of accident? (circle one) Yes No

Did you lose time from work as a result of this accident? (circle one) Yes No

If so, amount of loss time: _____

INJURED PARTY'S GENERAL & MEDICAL HISTORY

Any claims filed in the last 3 years? (circle one) Yes No
If so, please list dates, county, and disposition or status: _____

_____

_____

_____

Any previous medical conditions? If so, please list: _____

_____

WITNESS INFORMATION

Witness Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

Witness Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

INJURED PARTY'S MEDICAL INFORMATION

Please describe your injuries: _____

_____

_____

Do you have photos of your injuries? (circle one) Yes No

Were you taken by ambulance from the accident scene? (circle one) Yes No

If yes, please give name of hospital: _____

First date of treatment: _____

List all treating physicians, physical therapist, clinics, radiologists, etc (please include phone numbers for each):

_____

_____

_____

_____

Have your daily activities been affected by your injuries? If so, how? _____

_____

_____

INJURED PARTY'S HEALTH INSURANCE INFORMATION

Do you have health insurance? (circle one) Yes No

Health insurance policy no.: _____ Policyholder: _____

Name of Carrier: _____

Do you have Medicaid? (circle one) Yes No Do you have Medicare? (circle one) Yes No

Do you have a county card? (circle one) Yes No Please give card number: _____

DEFENDANT DRIVER INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

County: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Driver's License No.: _____ State Issued: _____

Date of Birth: _____

Did defendant driver receive a ticket? (circle one) Yes No

If so, give reason: _____

Was the defendant driver DWI or DUI? (circle one) Yes No

DEFENDANT VEHICLE INFORMATION

Year: _____ Vehicle Make: _____ Vehicle Model: _____

License Plate No.: _____ Area of Damage: _____

DEFENDANT DRIVER INSURANCE INFORMATION

Company: _____

Address: _____

City/State/Zip: _____

Policy No.: _____ Claim No.: _____

Adjuster Name: _____

Phone: _____

Fax: _____

DEFENDANT OWNER INFORMATION

Name: _____

Address: _____

City/State/Zip: _____ County: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Relationship to driver: _____

DEFENDANT OWNER INSURANCE INFORMATION

Company: _____ Phone: _____

Address: _____

City/State/Zip: _____ County: _____

Policy No.: _____ Claim No.: _____

Adjuster: _____

CONTACT WITH DEFENDANT'S INSURANCE COMPANY

Have you been contacted by the defendant's insurance? (circle one) Yes No

If so, have you given a statement? (circle one) Yes No To whom? _____

Was an offer of settlement made? (circle one) Yes No If so, amount offered: _____

Date offered: _____