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INTAKE FORM FOR AUTO ACCIDENT REPRESENTATION

Name:_____
last first m.i.

Address:_____
street city state zip

Telephone:_____
home/cell work

SSN:_____ DOB:_____

1. Date of accident (for statute of limitations purposes):_____

2. Names of parties, co-defendants, victims, etc. (for conflict of interest purposes):_____
_____
_____

3. Were you at fault?_____Were you or the other driver insured?_____

4. Did you receive medical treatment?_____If yes, how much are your bills and what are the names of the health care providers?_____
_____
_____

5. Are you still receiving medical treatment?_____

6. Have you signed any waivers or endorsed any check form an insurance company relating to this incident?_____If so, is this "PIP" related or for a total settlement?_____
_____

7. Have you ever filed a claim against an insurance company for Auto Accident-related medical expenses in the past?_____ If so, what insurance company(s)?_____
_____

8. Did you receive a traffic citation for this incident?_____ What charges?_____
_____

9. Have you retained an attorney for this case yet?_____ If so, provide his or her name, address and telephone number:_____
name address telephone

10. If yes to question 9, why are you seeking new counsel?_____

11. Describe in your words what led to the accident and the extent of your injuries: